			1 - For State Registrar	State of	Marylar				ealth a Death	and M		giene 2 Reg. No.	004	The stay of the st	001
	Physic	ian	1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	ath Day	Yeer	3. Time of	
	/Medi		Alberta			ay	1				2	6	04	7PM	M
	Exami	ner	4a. Facility Name (If not institution, give				_ ′		Location o	f Death			unty of Death	1	
	Euporal		5233 Linden H			last birthday)		ltin	If Under 2		8. Date of Bir		/A 9. Birth	place (State o	or Foreign
	Funeral Director			□м 21ДГ	99	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da 8-18	-04 <sup>r)</sup>	s.c	aroli	na
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside C	,
	Ba-f a	Director	Md. N/A		В	altim	ore							1X Yes	2 No
	with th	Dire	10e. Street and Number					p Code				-	of What Cou	untry?	
	eath v	eral	652 Melvin DR	12. Was Decede	ent Ever in L	IS 13		2123		nin? (Sne	orify Yes or No	US 14	A Race - Amer	ican Indian.	
36	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show dical Exercities free notified at	by Funeral	1 ☐ Never Married 2 ☐ Married  3 ② Widowed 4 ☐ Divorced	Armed Force 1  Yes 2 If Yes, Give Year or Date	es? <b>C</b> Mo		If Yes, spe		n, Mexican Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, White ecify: B1	, etc.	
Maryland 21215-0036	n 72 hours "naturel", colcal Exp	ted	15. Decedent's Ed	ucation		16a. Dece				of work		16b. Kind	of Business/I	ndustry	
218	d within 7 piene. r than "r It's Med	Completed	(Specify only highest gra	College (1-4	or 5+)	life.	DO NOT i	ise retired	turing most )	OF WORK	ng				
121	illed within I Hygiene. other then "		12 17. Father's Name (First, Middle, Last)	1 1-2		Nu	rse	Aid	10 Motho	r's Name	(First, Middle			y Hos	<u>pita</u>
anc	ed at a	9 Be	17. Fallier's Name (First, Middle, Last)	UNIC					Hon		V.	Bell			
ary	d 2 should th and Men 7 is marke traumatic	ပ္	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addres	s (Street a			I Route Numb			ip Code)	
	12 ha		Anthony Bell	Nephev	V	523	3 Li	nder	n Hei	ht	Ave,1	Balti	more,	Md. 2	1215
ore	ges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from Str		Place of Dispo cemetery, crei	osition (Na matory or	me of other place	θ)		ate		ion - City or 1		
Ë			'4 Donation 5 Other (Specify		*10	Baltimo	re Nati	onal Ce	emetery		02/20/04	Ca	atonsville	, Marylan	d 
Baltimore,	permit. Pag Department important: I any injury c once.		21. Signature of Funeral Service Licen	ep /		22	2. Name a Este 1300	$\overset{\scriptscriptstylend}{P}\overset{\scriptscriptstyleAddres}{Eut}$	of Facility Other	rs Iac	Funers e,Bal	al Se timor	r,P.A e;Md.	2121	.7
П			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	olications that cau	sed the deat h line.									Approximat Interval Bet Onset and	tween
8760,	/Medical Examiner  obvious and printing-transit	Ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or	as a consec as a consec as a consec	quence of): quence of).			vier		Jeen				
O. Box 6	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 □ Live birth 4 □ Pregnan 9 □ Unknow	n 2 ☐ Feta t at time of c	al death 3	Ectopic p					23d	. Date of deliment		Year
rds, P	quires that in signed b uid be deta	by	Part II. Other significant conditions o	ontributing to deat	h but not res	sulting in the u	nderlying (	cause give	en in Part I.			obacco use Yes 2□N		the cause of c	
I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was auto perfo		4b. Were aut prior to c death?	copsy findings ompletion of c	available ause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only o	one)			
of	Phys this ral dir	2	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of I		ER/Outpatier 28b. Time o		_	4 🗀 1401		ne 5 k Resi 28d. Describe			ify)	
on	Attending Ir death.	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Yeer)	Injury	м	28c. Injury Work 1 □ 1	o? Yes 2.∐N		Edd. Describe	now injury or	201100		
Division	r in in in	Certification;	3 Suicide 6 Could not be determined	28e. Place of	Injury - At h , etc. <i>(Speci</i>	ome, farm, str fy)	reet, factor	y, office			28f. Location (. City or To		umber or Ru	rai Route Num	nber,
×	To the Hospitel or Attan within 24 hours after deat To the Funeral Director; completely filled in by the	edical C	29a. Certifier (Check only one) 12 Certifying Ph	ysician: To the be iner: On the basi and manner	est of my kno s of examina stated.	owledge, deatl ation and/or in	h occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s	s)
	To the To the	Me	29b. Signature and title of cortillor				29	c. License	number	. 2	. 1	29d. Date si	igned (Month	, Day, Year)	
			16		Sta	5 MM2	ber.	1)	41	0	10	2	- 10	-04	
	3		30. Name and address of person who	completed garage	of death (Iter	m 23a) (759	Print,	6	2014	EW.	we, N	M			
* 8	Sta Regist		31. Date filed (Month, Day, Year)	A.	istrar's Signa	ature	WE!								

			For State Registrar	State of M	aryland	•	artment of		nd Men		iene 20 (	04002
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Evely) 4a. Facility Name (If not institution,	R		D	650	n, or Location o	F	Date of Deat Month	Day Y	Gear 3. Time of Death 13: 18 pm
_	Examin Funeral Director		University of	Maryland	e (In yrs. lasi	t birthday) 4 Yrs.	Ba / 1  If Under 1 Ye  Months Da	Amer ar If Under 2	e 24 Hrs.   8 F	Date of Birth Month, Day, A.Y. 18,		). Birthplece (State or Foreign Country) Mary Land
	B Maryland	ctor	Usuel Residence of Decedent           10a. State         10b. County           MD         N / A		10c. City, 1	fown or Lo						10d. Inside City Limits 1 ⊠ Yes 2 □ No
	is 1 and 2 should be filed within 72 hours after death with the Maryland of thealth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Modical Exacting Lines to notified at	Funeral Director	10e. Street and Number 2300 Mosher Str 11. Marital Status	eet  12. Was Decedent Armed Forces	Ever in U.S.	13. \	21216 Was Decedent		gin? (Specify			-
-000	within 72 hours after ene. than "natural", or Ite he Medical Exa cine	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced  15. Decedent*	If Yes, Give Year or Dates:	No	16a. Dece	1 ☐ Yes 2 🛣	No Specify:			Specify:	lack
C1717	be filed within 72 Ital Hygiene. Id other than "na event, the Moule	Completed	(Specify only highest Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, L	College (1-4or	5+)	life.	kind of work do DO NOT use re				Cosmetol	
aryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	Abraham Lincol  19a. Informant's Name/Relationsh	n Russell ip (Type, Print)				Ruby	West r or Rural Ro	ute Number	, City or Town, St	ate, Zip Code)
TIOLE, IM	Pages 1 and 3 nent of Health int: If item 27 iry or other tr.		Ms. Darilyn Dok  20a. Method of Disposition  1 Burial 2 Scremation  4 Donation 5 Other (Sp	3 □Removal from State	20b. Plac	e of Dispo	Mosher sition (Name or natory or other ake Cren	place)	, Balt Date Feb 200	9	, MD 212 20c.Location-C Beltsvíl	ity or Town, State
Baitimo	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L	içensee Mi	J698U	22	Name and Ac Cremati 8717 Gr	dress of Facility on and een Pas	Funera tures	Drive		ore, MD
	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a. A s	ine.	6/e						Interval Between Opset and Death
68/6U,	eath certificate be executed  attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl	b. Due to (or as c. Due to (or a d	a consequer	nce of):	Fal	Film	of	Head	<b>~</b> ←	lhono
O. BOX 6	0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3	Ectopic pregna Other (specify				23d. Date Monti	
ecords, P	w requires that the been signed by th should be detache	þ	Part II. Other significant condition	ns contributing to death	out not resulti	ng in the u	nderlying cause	given in Part I.				ute to the cause of death?
VII Мес	The law ate has b page 2 sl	e Completed	Hypo the	nsion wordsin						24a. Was a autops perform	ned? de	ere autopsy findings available or to completion of cause of ath?  ☐ Yes 2☐ No
ō	ding Phys h. After this funeral dir	ation: To B	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investig		ury 2	VOutpatier 8b. Time o Injury	f 28c. I	Othor	rsing Home 28d.	5 Reside	ence 6 Other	
DIVISION		il Certification:	3 Suicide 6 Could r determi	and 288. Place of it	tc. (Specify)					City or Town	n, State)	or Rural Route Number,
•	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only one)  2   Medical (	examiner: On the basis and manners	of examination	n and/or in	vestigation, in r	ense number	th occurred a	t the time, d	ale and place, an	Month, Day, Year)
	Sta Regist	ate rar	30. Nam and address of person of the state o	2. Mayo	death (Item 2 rar's Signatur		Print) U	nvers	Gr of	Mary	a land f	medient Im ro My/

		1	State of Maryland / Department of Hea  1- State  Certificate of Development	Ith and Mental Hygiene
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Clyde William Dye	2. Date of Death Month Day Year  2 5 2 004 1:00 P M
	/Medic Examin Funeral Director	er	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Loc  FRANKLIN SQUARE I Social Security Number  6 Sex 7. Age (In yrs. last birthday)  If Under 1 Year   If I	ation of Death  4c. County of Death  A / C  Under 24 Hrs. 8. Date of Birth County)  Win. 8 (Month Pax Year)  8 (Month Pax Year)  9 Birthplace (State or Foreign County)  Montana
	0		Usual Residence of Decedent  10a. State  10b. County  MD  Baltimore  10c. City, Town or Location  Rosedale	10d. Inside City Limits 1 ☐ Yes 2X No  10g. Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or items 23s or 28s-f show ent, the Medical Examiner must be trufffied at	ral Di	10e. Street and Number  1236 Kahler Avenue  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispan Market Every 19. Avenue 19. Av	usA  Nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
2000	nours after dural, or item	þ	1 Never Married 2000 No If Yes, Give Korea 1 Yes 2000 No Significant Significa	specity: White
Maryland 21215-0036	filed within 72 h Hygiene.  ther than "natuent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  12  College (1·4or 5+)  Truck Driver	
/lanu /	should be filed ind Mental Hyg s markad othe umatic event,	To Be C	Clyde E. Dye	Mother's Name (First, Middle, Maiden Sumame) Audry Hawkes
e, mary	t and 2 sho Health and I lem 27 is me othar traume		Mary Margaret Dye wife 1236 Kahler Aver	Number or Rural Route Number, City or Town, State, Zip Code)  nue Rosedale Maryland 21237  Date 20c. Location - City or Town, State
Baltimore,	t. Pages rtment of rtant: If if		XXBurial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  21. Signal re of Juneral Service Licensee  22. Name and Address of	2/9/2004 Raspeburg  Facility Cvach/Rosedale Funeral Home
D D	Department of the control of the con		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, si shock, or heart failure. List only one cause on each line.	Avenue Rosedale Maryland 21237
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. \( \frac{\frac{1}{5} \cho mic}{5} \)  Due to (or as a consequence of):	
60,	be executed icien and burial-transit	ai Examiner		
.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic		23d. Date of delivery Month Day Year
ords, P.	w requires that is been signed by should be deta	Completed by Ph		n Part I.  23e. Did tobacco use contribute to the cause of death?  126 yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
Vital Records,	ysician: The law is certificate has b director, page 2 s	O	25. Was case referred to medical	autopsy performed? prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No  6. Place of Death Check onlone
on of Vi	ding Physici h. After this cer funeral direc	tion: To B	1 Yes 2 VNo Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA	4 Nursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  2 No
Division	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	the Hospit oin 24 hour the Funera	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	ion, death occurred at the time, date and place, and due to the cause(s)
	P W C S	2	Brender M.D. (PGY-1) RES	0000 2-5-2004
	I <sub>M</sub>	tate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	WALE DR BAITIMORE MU 1123
	Regis	trar	FEB 11 2004 Library Jr Janes	

DHMH 17 Rev 1/2001

Clyde Dye

		-		tate of Maryland	d / Depa		lealth and	Mental Hygi	_	) l <sub>4</sub> 0400l <sub>4</sub>
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	MIDUH3				2. Date of Death Month FEBRUARY	Day -05-2	
<i>&gt;</i>	Examin	er	NoRTHWEST HOSPIT	AL CENTE		,	LLSTOW	,~		TIMORE.
	Funeral Director		E12 20 7071	20XF 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1924	9. Birthplace (State or Foreign Country) MD
	deeth with the Maryland me 23a or 28e-f ehow rmat be notified at	lor	Usuel Residence of Decedent  10a. State 10b. County  MD BALTIMO		Town or Lo	IMORE	-			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28e	Director	10e. Street and Number			10f. Zip Code	01000	10	g. Citizen of Wh	-
٥		Funerai	2803 QUARRY HEIGHT:  11. Marital Status  1 Never Married 2 Married	WAY Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give	i	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	21209 ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- no Rican, etc.)		U.S.A. - American Indian, White, etc.
2-003p	72 hours after netural', or ite alcal Examina	sted by	3 ☐ Widowed 4 [XDivorced  15. Decedent's Educati (Specify only highest grade or	Year or Dates:	16a. Dece	dent's Usual Occup	ation during most of w	orking 1	6b. Kind of Bus	WHITE iness/Industry
1717	withir Bne. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SALE	DO NOT use retired	1)			CLOTHING
yland	uld be filed fental Hygir rked other tic event, II	To Be (	17. Father's Name (First, Middle, Last) ALEXANDER		PROF	PER	18. Mother's Na ROSE	ame (First, Middle, M	aiden Sumame	STEIN
Mary	s t and 2 should f Heelth and Men item 27 le marke other treumatic		19a. Informant's Name/Relationship (Type, MARILYN AXELROD /					Rural Route Number, WAY - BAL		
Jore,	M O		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	emetery, cre	osition (Name of matory or other place	- 1			STOWN, MD
Baitimore,	permit. Page Department Importent: If eny injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature a Funeral Service Lice see	)   BEI	2	MEMORIAL  2. Name and Addre	ss of Facility	OL LEVINS	ON & BR	OS., INC.
	405.4		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	op that caused the death use on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		1515				3.1337, 2.13 3.32.17
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	TN 8	Nomv	MA.			
	e be executed /sicien and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a consequ	uence of):					
09/89	physiciens the burns the burns	<u></u>	d							
.O. Box (	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date Mont	of delivery th Day Year
۵.	ires that the signed by	þ	Part II. Other significant conditions contri DEMENTIA	buting to death but not resu	ulting in the u	underlying cause giv	ven in Part I.			bute to the cause of death?
Recor	he law require e has been si ige 2 should t	Completed						24a. Was ar autops perform	prod2 de	fere autopsy findings available for to completion of cause of eath?
/ital		Be Co	25. Was case referred to medical examiner?					1 ☐ Yes 2 eath Check only one		3165 2010
Division of Vital Records,	ding Ph h. After th funeral	tion: To	1 1 105 2 NO	pital: 1  atient 2  2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur		Home 5 Reside		
Divisi	l or Atten after deal Director:	Certification:	a Could not be	28e. Place of Injury - At he building, etc. (Specify	ome, farm, si	reet, factory, office		28f. Location (Sti City or Town		r or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	Medical C		ian: To the best of my kno r: On the basis of examina and manner stated.						
)	To the within To the compl	Me	29b. Signature a rivide of certifier	PHYSICIA	1	29c. Licens	t 2723		ed. Date signed	(Month, Day, Year) Y 85 2004
	le		30. Name and address of person who com	pleted cause of death (Item	23a) (Type	Print) NOF	THWE 1 OL	D COURT	ROAD	My 21133
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 1 200	32. Registrar's Signa		books				
DI	HMH 17 Rev 1/2	2001		The state of the s	19			-		

		,	For State Registrar	State of Marylan	nd / Depa <i>Cei</i>	artment of F	lealth and Death	F	leg. No.	004		05
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Later Chap) 4a. Facility Name (If not institution, give	man Fitzel	11	4b. City, Town, o	r Location of De	2. Date of Dea Month February	Day	Year 2004 hty of Deeth	3. Time of De	
	Funeral Director		Union Memorial House 5. Social Security Number 6. S 215-14-9859	ex 7. Age (In yrs.	last birthday)	Baltimo If Under 1 Year Months Days	ore If Under 24 H Hours M		r. Year)		e City lace (State or F try) yland	≓oreign
	death with the Maryland ms 23a or 28a-f ehow must be notified at	Director	Usuel Residence of Decedent  10a. State 10b. County  MD Baltime  10e. Street and Number		ty, Town or Lo				10g. Citizen o		0d. Inside City 1 ☐ Yes 2	
98		Funeral	11217 Pfeffers  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1∑Yes 2 ☐ No IfYes. Give	1	21087		(Specify Yes or No- erto Rican, etc.)	U.S	A. ace - America lack, White, e	an Indian,	
Maryland 21215-0036	filed within 72 hours after Hygiene. Ither than "natural", or ite ent, the Medical Examine	Completed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Et (Specify only highest grade)  Elementary/Secondary (0-12)  12	Year or Dates: WW I	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation	working	16b. Kind of	Whit Business/Ind		ustro
aryland 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last, Vernon Thomas I  19a. Informant's Name/Relationship (	Fitzell			Cathe	lame (First, Middle, rine Chap Rural Route Numbe	Maiden Suma man	ame)		<u>-</u>
Baltimore, Ma	permit. Pages 1 and 2 Department of Heelth a Important: if item 27 is any injury or other tra once.		William S. Fitze  20a. Method of Disposition  1 \overline{\text{M}} \text{Burial 2 \overline{\text{Cremation 3 \overline{\text{C}}}}  4 \overline{\text{D}} \text{Donation 5 \overline{\text{Other (Specification 3)}}	Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	t - Balti Date /09/2004	20c. Location	n - City or Tov		and
Balti	permit. Departn Imports any inji		21. Signature of Funeral Service Licer  21. Signature of Funeral Service Licer  22. Part 1. Enter the disease, or com	asses  Characteristics of the control of the contro	22	Name and Addre	ss of Facility ir Road	E. F. Las: - Kingsv	sahn Fi ille, 1	uneral MD 21	Home, 087	P.A.
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Per i cada  Due to (or as a consec		usion				1.0	Interval Betwe Onset and De	ath
8760,	ate be executed hysicien and the burial-transit	licai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	b. Due to (or as a consect of the consec								
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnant Live birth 2 Fete 4 Pregnant at time of c	eldeath 3[	Ectopic pregnancy	1		1	Date of deliver	ry Day Yea	ar
	iaw requires that the de as been signed by the a 2 should be detached f	ρ	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause giv	en in Part 1.				e cause of dea	
al Rec	The ate has page	e Completed	25. Was case referred to medical						sy med? 2 🗌 No	prior to con death?	osy findings avanted in the second se	ailable ise of
Division of Vital Records,	ng Phys fter this ineral di	To B	25. Was case referred to medical examiner?  1  Yes	28a. Date of injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injur Wor	er: 4 🗌 Nursing	Death (Check only or g Home 5  Resid 28d. Describe h	ence 6 🗆 O		)	
Divisi	To the Haspitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not b determined	e 28e. Place of Injury - At h building, etc. (Special	fy) 	eet, factory, office	- 04,00	28f. Location (S City or Tow	n, State)			€.
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one) 2 ☐ Medicel Example 129b. Signature and title of certifier	nysician: To the best of my knominer: On the basis of examina and manner stated.	owledge, deatl ation and/or in	vestigation, in my o	pinion, death or	courred at the time, o	late and place	e, and due to	the cause(s)  Dav. Year)	
	61		30. Name and address of person who	Lu, M.D. completed cause of death (Iter	m 23a) (Type,	Print)		-D8			200	4
	Sta Registr		31. Date filed (Month Pay Year) 20	201 East Uni 04 Registrar's Sign	versity here	Parkiva	y, Balt	imore , M	·D. 21	1218		:

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** February 6 2004 12:11 p<sup>M</sup> Fu1k /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Fecility Name (If not institution, give street and number) Examiner 233 Marganza South Laurel Anne Arundel Honder 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 30, 1 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral X**XM 2□ F 80 Indiana Director 311-20-3106 1923 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
and: if Item 27 is marked other than "natural; or Items 23a or 28a-f show ury or other traumatic avent, the Medical Examine must be notified at 1 ☐ Yes 2√ No Completed by Funeral Director Anne Arundel Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20724 233 Marganza South USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) NSA Cryptologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Fulk Norma Dayhuff P 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen V. Fulk (Wife) 233 Marganza South, Laurel, MD 20724 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2/10/2004 Lakemont Mem. Gdns Davidsonville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Valuel 12 Ridgely Avenue, Annapolis, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finaf PYLMONARY EMBOLISM **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner DEEP VENOUS THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of defivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) detached t 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page certificate 1 Yes 2.7 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home supplesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending No trie recent within 24 hours after death.

To the Funeral Director: All 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 @ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Centa kle D0052490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltoner 3001, S. Haniver st Anita Khandelwal MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar FEB 1 1 2004

State of Maryland / Department of Health and Mental Hygiene 04007 State Registrar-AMEND ITEM #18 PER FH G 828 2/11/04 CHertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day February T 2004 2:00 PM **Physician** FALK 2004 **JEROME** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A LEVINDALE HEBREW HOME BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth FEB. 2,1920 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F MD 219-05-0023 84 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State in then "naturel", or items 23s or 28s-f show the Medical Examiner count be notified at 1 Ves 2 □ No N/A BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. BELVEDERE AVENUE 2434 W. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. MYes 2 ☐ No fYes, Give 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No 21215-0036 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) WASTE WATER TREATMENT ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be FRESNICK ZELDA RESNICK FALK **JOSEPH** ٩ nt of Health and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 RAINDROP CIRCLE - REISTERSTOWN, MD 21136 JOSEPH FALK / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: If any injury or once. GREATER BALTIMORE LODGE 2/9/2004 BALTIMORE, MD 21. Signatural Service License 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication shall caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition days **Physician** POSIS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) .O. Box 68760, Physician/Medical as the t the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □ Yes 215 AND 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 1 Yes 1 Tyes certificate or Attending Physician: 26. Place of Death (Check only one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Chath 28b. Time of 1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 T Suicide 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Levinda Usun 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar 2004 1

			For State Registrar	i louc	S	State of	f Mary				t of H	lealth	and M	lental Hy	/giene	4 U	04	0400	8
			1. Decedent's Nam	e (First, Middle,	Last)									2. Date of Do	eath Da	4	Veer	3. Time of Death	
	Physicia		Louis			1	L.		G	anzer	mill	er		02	0	7 2	004	4:03 p. M	١.,
	/Medic Examin		4a Fecility Name (	If not institution,	give stre	et and nur	nber)	i		4b. City,	Town, or	Location	of Death		40	. County o		21-0	
			Frankli	n Sain	are	HUS	pita	al			KOS	edo	ale			Ba	-	nore	
	Funeral		5. Social Security N		6. Sex	-5.5		n yrs. las	st birthday)	If Under Months	1 Year Days	If Under	r 24 Hrs. Min.	8. Date of Bi (Month, D January	irth av. Year		9. Birthpla	ace (State or Foreign ry)	п
	Director		220-20-01	162	X M	2 🗆 F	76		Yrs.	WOTHIS	Days	110013		January	7,192	28	MD.		
	P		Usual Residence o	Y			140	On City	Town or Lo	111177							10	d. Inside City Limits	_
_	arylar ehow	-	10a. State	10b. County			10										10	1X Yes 2 No	
7	the Ma	cto	MD.	N/A				Dal	Ltimor										
1	it th	Fig	10e. Street and Nu							10f. Zip						tizen of W USA	hat Count	ry?	
miller	atter death with the Maryland or Itams 23a or 28a-f ehow IIT ear Itala by Lettfled at	Funeral Director	4001 Ove	eriea Av									0 /0-	N N			- America	n Indian	_
3	tams	nue	11. Marital Status			Was Dece	rces?	er in U.S.	. 13.	Was Deced	dent of H cify Cuba	ispanic Oi in, Mexica	rigin? (Sp in, Puerto	ecify Yes or N Rican, etc.)	10-		, White, e		
36	s afte	by F	t ☐ Never Man	ried 2 Marrie	bd	lX Yes If Yes, Giv	2   No			1 ☐ Yes	<b>⊉C</b> XNo	Specify	<i>r</i> :			Specify:	Whit	e	
28	n 72 hours "natural", adical Exa	₽ P	3 <u>7</u> 1 ***dowad	15. Decedent	e Educat	Year or D	4185.		16a. Dece	dent's Heur	al Occup	ation			16h K	(ind of Bus	iness/Ind	ustry	_
NE	n 72	iete		cify only highest		ompleted)			(Give	kind of wo	rk done d	during mo	st of work	ing	100.1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3311 y	
53	within 72 ene. than "na	Completed	12 years			College (1	1-4or 5+)			trici		•			Che	mica.	l Com	pany	
8 B	be filed withintal Hygiene. Id other than event, the M	ŭ	17. Father's Name		ast)							18. Moth	ner's Name	e (First, Middle	e, Maider	Sumame	)		
ans	d be antal	To Be	Josef Gar	nzermil.	ler							Eli	zabet	th Cier	znak				
5 GO	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other traumatic event, the Magnes.	F	19a. Informant's N	lame/Relationsh	ір (Туре,	Print)			19b. Maili	ng Address	(Street	and Numb	ber or Run	al Route Numi	ber, City	or Town, S	State, Zip (	Code)	
S	and 2 sealth as n 27 is		Elizabet	h Samm	I	Daugh	ter		5923	Davbr	eak	Terr	ace,	Baltim	ore,	Md.	21206	5	
, e	Hea Hea tem		20a. Method of Dis			- u u j		20b. Pla	nce of Dispo	sition (Na	ne of		Febru			ocation - 0			_
20	Pages nent of ant: If it ury or o			☐Cremation 5☐Other (Sp		noval from	State		kwood					2004	Par	kvil	le MC	)	
LOUI Baltimore,	nit. Par bartmen ortent: injury	1.1	21. Signature of F		-		2					,						•	_
Ba	permit. Departr Importe eny inji		Char	thouse	(	. (	AN A	0						ome Of Road,				21222	
	glos N		23a. Pert1. Enter shock, or hea	the disease or	complicat	tions that o	aused the	e death.	Do not en	ter the mod	le of dyin	g, such a	s cardiac	or respiratory	arrest,	arry1		Approximate	
	9 10		shock, or hea		only one	cause on e	ach line.		)	1 1								Interval Between Onset and Death	
	Physician /Medical		disease or conditi- resulting in death)	on	a	ten	for as a co	cr.	- hy	hm	4								
	Examiner					Due to	(or as a co	onseque	ence on.										
(1		er	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	onditions, mmediate	b	Due to	(or as a co	onseque	ence of):										_
0	uted Insit	Examiner	cause (Disease o	erlying r injury															
7	be executed icien and buriat-transit	Exa	that initiated event resulting in death)		C	Due to	(or as a co	onseque	ence of):										
760,	te be ex ysicien ne buria	cail		1	<b>U</b> a.														
89	ificat g phy as th																		-
X	ndin use a	Z	IF FEMALE: 23b. Was deceded	nt pregnant	23c.	. If yes, out				75						23d. Date	of delive	у	
m	death e atte	icia	in the past 12 1 Tyes 2			4 Pregr	oirth 2 🗍 nant at tim			∃Ectopic p ∃ Other <i>(st</i>						Mon	th I	Day Year	
0	thet the death certifical ed by the attending phy detached for use as th	hys	9 🗆 Unknow			9□ Unkn	own				-								
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires thet the death certifical roleath. •ctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other sign	ificent conditio	ns contri	buting to d	eath but n	not result	ting in the u	nderlying o	ause giv	en in Part	J.	23e. Did	tobacco	use contri	bute to the	e cause of death?	
Ę	w require been sig should b	ba	1)em	physe	ms									1	Yes 2	□No	3 Proba	ably 4 □Unknown	٦
8	aw requas been 2 should	ojet	21000	-0 mc-	7	1500	se							24a. Wa		24b. W	ere autop	sy findings available	е
Re	fhe lav te has age 2	E			1									per	opsy formed? 2 ♣ No	d	eath?		
ta	ician: Th certificate rector, pag	BeC	25. Was case refe	erred to medical								26. Plac	e of Deat	h (Check only					_
; <del>-</del>	ysici	To B	examiner?	] NO	Hos	pital:	Inpatient	2 🗓 🛭	Poutpatie	nt 3 D	Oth Oth	or		ome 5 ☐ Res		6 □Othe	r (Specify	)	
0	g Phys er this eral de		27. Manner of Dea			28a. Date	of Injury	ear) i	28b. Time o	f :	28c. Injur Wor	y at		28d. Describe	how inju	iry occurre	ed		
<u>.</u>	ndin ath. r: Aft	atio	1 ☑ Natural 2 ☐ Accident	5 Pending investig		(10101)	in, buy i	oui,	mjury	М		Yes 2	□No						
Vis.	Atte	illi	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi		28e. Place	of Injury ing, etc. (S	- At hon	ne, farm, st	reet, factor	y, office			28f. Location	(Street a	nd Numbe	r or Rural	Route Number,	
ō	tel or rs aft el Dir	Certification:		-		Julia	. 3, 4.0, [1	, 22.19/		15									
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only	1 Certifyin	g Physic Examine	r: On the b	asis of ex	aminatio	rledge, deal	h occurred	at the tin	ne, date a	ind place, eath occur	and due to the	e cause(s	and mar	ner as sta nd due to	ated. the cause(s)	
	the hin 24 the fundamental the	Medical	one)				ner stated									ate signed			
	Vit To Con	-	29b. Signature an	a tine of certifier	> /	VI	10	m		29		o number 0 5 5			23U. Di	Le Signed	n i i	ruj, iodi)	
	1		00	4	~ //		R		ر		D ()	レンコ	7 ()			17/	47		
	1		30 Name and do	dress of person	m) mi	pleted call	se of deat	th (Item	23a) (T e.	Print)	East	Sail	OVO	Drive	L	411		MA DIS	12
			31. Date filed (Mo	oth Day Vaari	4.4.14	20 5	Registrar's	Signati	ure (	MIT I	1443.3	390	INC	1			1110	.410	
	Sta Registi		S. Date med (MO		4 200		ho	سالها در د	1 1	1	100	100	6						

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Ma		d / Depa	artme	nt of H	ealth ar		-		•	. nl.nr	79
			1 - Stata Registrar			Cei	rtifica	te of L	Jeath			g. No.			and and
	Physicia	20	Decedent's Name (First, Middle, Las								Date of Deat     Month	Day	Year	3. Time of Deat	
	/Medic		Barbara Sue Giann								Feburary		2004	1031 A	
	Examin	er	4e. Facility Name (If not institution, give				4b. City		Location of			4c. C	ounty of Dea		
0.	9		3146 Ryerson Cirl		- //	( 4 t lat d )	If I lode	La er 1 Year	nsdowr		P. Doto of Birth			timore	nian
	Funeral		5, Social Security Number 6. Se	ex □M 2]X[]F	e (in yrs. 6	last birthday)  Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day,	Year)	4.2 9. Bir	thplace (State or For ountry) Ohio	ыдп
	Director		217-40-1380 Usuel Residence of Decedent		0	0					Apr. 22	, 15	+3	OILO	
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Lin	nils
	Mary f sh	to	MD Bal	Ltimore			Lang	downe						1 🗌 Yes 2 🗇	No
	28a	Director	10e. Street and Number	LLIMOLU				ip Code			1	0g. Cilize	on of Whal Co	ountry?	
	72 hours after death with the Maryland Instural; or itema 23a or 28a-1 show dical Exactinet must be motified at		3146 Ryerson Circ	:1e					2122	27		Uni	ted St	ates	
	ma 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Dec	edent of Hi	spanic Origi	in? (Spe	cify Yes or No- Rican, etc.)	14	Black, Whi		
0	after or its	2	1 Never Married 2 Married	1 Yes 27		1	1 🗆 Yes		Specify:					hite	
3	rai',	d b	3 Widowed 4 Divorced	Year or Dates:			103	- A							
212-0030	72 h 'natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece (Give	kind of w	rork done o	turing most o	of workii	ng	16b. Kind	d of Business	/Industry	
V	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		omem	alcor	)				Own Ho	me	
N	be filed within 72 hours after death with the Marylan Hygiene.  de Hygiene.  de other than "natural; or Itama 23a or 28a-f show and, Ira Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)		· · · · ·	11	Omem	akei	18. Mother	's Name	(First, Middle, i				
yland	id be f lental f ked of	o Be	Thomas Waugh								Smith				
Ž	2 should be and Mental is marked raumatic ev	Ĕ	19a. Informant's Name/Relationship (	Type Print)		19b. Maili	na Addre	ss (Street a			I Route Number	City or	Town, State,	Zip Code)	
Mar	d 2 s th an t7 is traus			Husband			-				ansdown				
a)	1 an Heal Iem 2		20a. Method of Disposition	lasbana	20b. F	Place of Dispo	osition (N	ame of				-	ation - City or		
ᅙ	ages ont of t: If i		1 XBurial 2 □ Cremation 3 □ □ Donation 5 □ Other (Specify	Removal from State	Ne	w Cath				-3-2	004	Balt	imore,	MD	
saitimore,	artme ortan injur		21. Signature of Funeral Service Licen			Ceme	tery 2. Name	and Addres	ss of FacilAvi	mbro	se Fune	ral 1	Home,	Inc.	
n	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev <u>000.08</u> .	1	Coll Chang N C	DIVINO	1138	13	28 S	u1phu	r Spr	ing	Rd., Ar	butu	s, MD	21227	
19	The Sec		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the deat	th. Do not en	ter the mo	ode of dyin	g, such as ca	ardiac o	or respiratory arr	est,		Approximate Interval Between	1
	Physician		Immediate Cause (Final	V=1-,	color	otic Co	adi	MACCI	lasi	)ico	2003			Onset and Death	1
	/Medical		disease or condition resulting in death)	a. Due to (or as			0,0.0	, 00,900		00,32	430			10 4201)	
	Examiner		Securation list conditions	b											
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consec	quence of):									
)	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as		woman of):									
ĝ	te be executed ysicien and e burial-transit	cai E		Oue 10 (01 as	a consec	querice or).									
289	leath certificate   attending physi	dice		d											
	ding se as	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregn	ancy						23	3d. Date of de	livery	
ROX	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	al death 3	☐Ectopic☐Other (	pregnancy specify)					Month	Day Year	
o.	the d	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown				,, <u>-</u>							
J.	The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the		Part II. Other significent conditions of	ontributing to death t	out not res	sulting in the u	underlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute t	o the cause of death	1?
Vital Records,	n sign	d by									1 🗆 Y	es 2	No 3□P	robably 4 Unkn	own
<del>ပ</del> ္ပ	w req	Completed									24a. Was a		24b. Were a	utopsy findings avail	lable
E E	he la e ha: age 2	m d									autop:	med? 2 X No	death?	completion of cause s 2 No	) OI
g	ifficat or, pa		25. Was case referred to medical				-		26. Place o	of Death	1 ☐ Yes	-	1010	3 20110	
	ysiciu s cer direct	To Be	examiner?	Hospital: 1 ☐ Inpati	enl 2	] ER/Outpatie	nt 3 🗆 [	Oth-			1 -		Other (Spe	ecity)	
0	g Ph er thi		27. Manner of Death	28a. Dale of Inju	ury av Year)	28b. Time o	of	28c. Injun Wor	y at	1	28d. Describe h	ow injury	occurred		
Ö	ath. r: Afr	atlo	1 Natural 5 Pending investigation	n	, ,		М		Yes 2□N	lo					
Division of	r Atte	Certification:	3 Suicide 6 Could not b 4 Homicide determined		jury - At h	nome, farm, st	reet, facto	ory, office			28f. Location (S City or Tow		Number or F	lurai Route Number,	
	ital c rai D lled ir														
	Hosp 14 hou Fune tely fil	Medical	(Check only 2 Medical Exer	nysician: To the best miner: On the basis of	of examina	owledge, deat ation and/or in	th occurre ovestigation	ed at the tin on, in my o	ne, date and pinion, death	place, a h occurr	and due to the d ed at the time, d	ause(s) a late and p	ind manner a place, and du	s stated. e to the cause(s)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier	and manner s	iaioù.		2	9c. Licens	e number		2	9d. Date	signed (Mon	th, Day, Year)	
	8 4 8 4		PLE III ( L AND	. 0 .	1.			Nich	47		I	oh.		20011	
	K		30. Name and address of person who	completed cause of	death te	m 23a) (Type	Print)	V106	1 4			- 240	iry 2	, 2004	
			Philip-Militelle	and Co	Trum	blate	tille	CIL	ather	wil.	Le, Mar	vlai	1 d 21	,2004	
	Sta	ate	31. Date files (Month, Day, Year)	32. Regist	rar's Sign	ature					-	1	-		
	Regist	rar	EED 1 1 200	A France	and a	1-	A.	- 1	,						

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Ma	aryland /		rtment			ınd M		giene Reg. No. 2 (	004	04010
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  MILDRED	607	HRI	Ë					2. Date of Dea Month Februa	Day	<b>Year</b> 2004	3. Time of Death 11:15 A M
Examin	. 10	4a. Facility Name (If not institution, give s Frederick Villa N  5. Social Security Number 6. Sex	ursing &	Rehab.	birthday)	4b. City,	(	Location o Caton	svil	8. Date of Birth	4c. County Balt:	imore	place (State or Foreign
Funeral Director			M 2☑F		Yrs.	Months	Days	Hours	Min.	(Month, Day Jun 23	v. Year)	PA	ntry)
B Maryland	ctor	MD Howard		10c. City, To		cation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the	Funeral Director	10e. Street and Number 6636 Washington Bl	.vd., Lot	45		10f. Zip 210					10g. Citizen of United		•
within 72 hours after death with the Maryland with a "Te hours after death with the Maryland ene."  Han "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	/		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Rad Bla Specil	ck, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Manual Hygiens. Importent of Health and Manual Hygiens are importent in them 23e or 28e-1 show any injury or other traumatic event, the Madical Examinar must be notified at 90ce.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	i+)	(Give life. l	dent's Usua kind of wor DO NOT us	k done d e retired)	ition uring most	of workii	ng	16b. Kind of B Drug S	usiness/Ir	
Should be filed and Mental Hygis marked other umatic event,	To Be Co	17. Father's Name (First, Middle, Last) Boyd Jackson						Mabe	1 J	ackson	Maiden Sumar		
and 2 sha alth and 127 is m er traum		19a. Informant's Name/Relationship (Type Ms. Sandra Gardne:		r	6636	Wash.	ingt	on Bl			or, City or Town , Elkri		MD 21075
ages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place ceme Ches		sition (Nam natory or ol 1ke Cr		1	E	Pate Feb 11 2004	20c. Location Beltsv.		
Daillino permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service License		M00382	22	. Name and Crema	d Addres	s of Facility	y Fune	eral Alt	ternati	ves	98%
Physician		23a. Part1. Ent. the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin	the death. D				, such as	cardiac o		e Balt rest,	rmore	Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	ea of):				_	T. T.			•
w requires that the death certificat requires that the death certificat been signed by the attending phy should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  10 No	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pro						ate of deliventh	ery Day Year
ords, F.O	ρ	Part II. Other significant conditions con	081)			nderlying ca	ause give	n in Part I.			obacco use con (es 2 🗆 No	tribute to t	he cause of death?
The lay ate has page 2	Completed	J.	Typothy	rigin.	$\sim$					24a. Was autop perfor 1 Yes	rmed? 🔟	death?	opsy findings available impletion of cause of
Attending Physician: The relation of the relat	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1  Accident investigation	ospital: 1  Inpatie 28a. Date of Inju (Month, Da		Outpatier o. Time of Injury		8c. Injury Work	or: 4 - Nu	rsing Hor		ne) dence 6 ⊡Otl now injury occur		(y)
i Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At home, c. (Specify)	farm, str	eet, factory	, office		:	28f. Location (S City or Tow		ber or Run	al Route Number,
Hos Funda Pel	edical (	29a. Certifier 1. Certifying Phys (Check only one) 2 ☐ Medical Examin		f examination									
To the within 2 To the complete	M	29b. Signature and title of certifier	on Co	9HEN	5-1	290	. License	number 369	42		29d. Date signe	ed (Month,	Day, Year) 10, 2004 28
4		30. Name and address of person who co B TUNAKIII A M 31. Date filed (Month, Day, Year)	y 1009,	death (Item 23 ar's Signature	44	Print) K Ri	). (	a fa	dur	le, 1	W) 2	12	28
Sta Registr		FEB 1 1 200		ar a dignature	A. S.	Septe 1	,						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 11:00 AM David Gilbert Gillespie January 27, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Lorien Rehab Center Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 7, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs Director 201-28-5105 New Jersey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Monroe Big Pine Key Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33043 30531 Anthony Street TISA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 △ Yes, Give 1 U / 8 / 40 to 1 □ Yes 2 ☒ No Specify: Year or Dates: 1 2 / 8 / 4 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White ģ 3 Widowed 4 Divorced 12/8/46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Freight 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Remington Harison J. Gillespie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Cantor - Daughter 2057 Mt. Hedron Dr. Ellicott City, MD 21042 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/5/04 Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility
The Neptune Society 21. Signature of Funeral Service Licensee 531 E. Oakland Park Blvd Ft. Lauderdale, FL 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician · CONGESTIVE HEART FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death Certification: 1X Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the deeth certificate be executed attending physicien end for use es the bunel-trensit Division of Vital Records, P.O. Box 68760, hes To the Hospital or Attending Physiwithin 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral di

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Heatth end Mentel Hygiene. Important: if Item 27 is marked other than "natural;, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

State

Registrar

edicai

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only

4 ☐ Homicide

FEB 1 1 2004

6 ☐ Could not be determined

100 dmo 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

\*\*Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D-29097

BOWIE MD

**DHMH 16 Rev 6/95** 

		For State Registrar	State of Man				Death		R	g. No.	w \ \ \ \ \	0 9 0 1
Physicia	n	<ol> <li>Decedent's Name (First, Middle, Last John Grothe</li> </ol>	(1)					-	Date of Deat Month anuary	Dav	Year	3. Time of Death 7:45 PM
/Medica		4a. Facility Name (If not institution, give	street and number)		4b. C	v. Town. o	or Location of De		andar y		nty of Death	
Examine		Joseph Richey H				altim					.,	
Funeral Director		5. Social Security Number 6. S 213-36-3526	TD	n yrs. last birthday) 62 Yrs.	If Un Month	der 1 Year S Days	If Under 24 H Hours Mi	rs. 8. (in. F	Date of Birth Month, Day, 2D 7,	Ye <i>ar)</i> 1941	g. Birth Cou Man	place (State or Fore intry) 'yland
a-f show		Usual Residence of Decedent  10a. State 10b. County  MD	10	De. City, Town or Lo		re						10d. Inside City Lim
Sa or 28	Funeral Director	10e. Street and Number 3102 Piquett La	no		10f.	Zip Code	000		1	0g. Citizen o		intry?
IIS 23	era	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was De		229 Hispanic Origin?	(Specify	Yes or No-		USA lace - Amer	ican Indian,
ar, or fter	by run	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No	1		pecify Cub 2X No	dispanic Origin? an, Mexican, Pue Specify:	erto Rica	n, etc.)		lack, White	
natur	Completed	15. Decedent's Ec (Specify only highest gra	ucation	16a, Dece	dent's U	sual Occup work done	pation during most of w d)	rorking		16b. Kind of	Business/li	ndustry
ygiene. Ier than t, the M	E CO	Elementary/Secondary (0-12)	College (1-4or 5+)			lisab	led			noı		
ed oth	a P	17. Father's Name (First, Middle, Last) Alvin Edward Gro	the				18. Mother's N				ame)	
mark matik	0	19a. Informant's Name/Relationship (		19b. Mailir	na Addre	ss (Street	Margar				n State Zi	n Code)
27 is 27 is r trau	1	Joseph Richey Hos					w Street					
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23s or 28s-1 shoy any injury or other traumatic event, the Medical Examiner must be motified at ODEs.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, crer	sition (A	ame of		Date		20c. Location		
Departri Imports any inju		21. Signature of Foregral Service Licen  Ronald S.	Wade, Direc	2000		and Addre	ss of Facility	5d <sub>1</sub> 6.	55 W.	Balti	more !	Street
ysician Medical		3a. Pa 1. Enter the disease, or company, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.		er the m	ode of dyir	ng, such as cardi					Approximate Interval Between Onset and Death
aminer	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a co									
ysicien and he burial-tran	cal Exa	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):								
been signed by the attending physicien and should be detached for use as the burial-transitional by Dhysicien and the Dhysicien Economics and the Dhysicien Economics and the Dhysicien Economics and the Dhysicien Economics	Physician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic Other	pregnancy specify)	/				Date of delived Month	ery Day Year
signed to	à	Part II. Other significant conditions of Bone met on		ot resulting in the u	nderlying	cause giv	ren in Part I.					the cause of death?
2 0 8	Completed	COPD							24a. Was ar autopsy	/	Were auto prior to co death?	opsy findings availab impletion of cause of
or, pa		25. Was case referred to medical					OS Plana A D			No	1 🗆 Yes	2□ No
his cert if direct	۵	examiner?	Hospital:	2 ER/Outpatien	t 3 🗆 i	Oth Oth	26. Place of Do				ther (Sneci	r) Hospice
: After this funeral dir		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of		28c. Injur Wor			Describe ho			Washington .
within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page  Modical Carellinashow, To De Comp		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, str Specify)	eet, fact	ory, office		28f. l	ocation (Str City or Town,	eet and Nun State)	nber or Run	al Route Number,
thin 24 hours the Funere empletely fille		29a. Certifier (Check only one) 1 Certifying Ph	vsician: To the best of m iner: On the basis of exa and manner stated	amination and/or inv	occurre estigati	d at the tir on, in my o	me, date and place pinion, death occ	ce, and courred at	fue to the ca the time, da	use(s) and r te and place	manner as s e, and due t	stated. o the cause(s)
To 11	2	29b. Signature and title of certifier	0		2	9c. Licens	e number		29	d. Date sign	ned (Month,	Day, Year)
		30 Name and address of person who		36 (Item 23a) (Tuna	Print	Doc	8583			1/31	12004	ı
State		30. Name and address of person who de G. Will Am BRN 31. Date filed (Month, Day, Year)	ED/CI 32 Registrar's	Signature	Print)	9						-

DHMH 17 Rev 1/2001

6/20 THE

JOHN

1/30/04 @74

			1 - For State Registrar	State of Maryland	-	rtment of I		_	giene Reg. No.	2004	04013
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last  CATHER NC F  4a. Fecility Name (If not institution, give	3 Hill		4b. City. Town,	or Location of Dea	2. Date of De Month	Day S	Year 2004 County of Deat	
	Funeral Director	er	5. Social Security Number 6. Se	5 BAYVIEW HOS	PITAL ast birthday) Yrs.	If Under 1 Year Months Days	LTIHOI If Under 24 Hrs Hours Min	S. 8. Date of Bir		9. Birt	BALTIMORE  Thiplace (State or Foreign  DUNTY)  TH CAROLINA
	Maryland s-f ahow ling at	tor	10a. State 10b. County  MARYLAND N/A		Town or Le	cation ORE C	nty				10d. Inside City Limits 1  Yes 2  No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23e or 28e-f ahow or other traumatic event, the Medical Examinational Be notified at	Funeral Director	10e. Street and Number	HENUE  12. Was Decedent Ever in U.S.	S. 13.1	2121		Specify Yes or No	и	izen of What Co	
9000	nours after durant, or them	by	1 Never Married 2 Married 3 StVidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates:		Yes, specify Cub	Specify:	rto Rican, etc.)		Specify BL	e, etc. ACK
21215-0036	d within 72 h giene. ir then "natu Ir e Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)		(Give life. I	lent's Usual Occup kind of work done DO NOT use retire USCWIF	during most of wo d)	orking		und of Business/	/Industry
<b>Maryland</b>	iould be filed Mental Hygi varkad other natic evant, II	To Be C	Truck It.	Dickerson			Pear		Rei	d	7-0-4-
	tom 27 is most shaped the street traum		19a. Informant's Name/Relationship (T. CARLTON D. 20a. Method of Disposition	H111	506 Z	PACEBR sition (Name of	ook C+	Locher Date	U, N	-	207
Baltimore,	permil. Pages. Department of himportant: if ite any injury or of once.		1 Seurial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature of Euneral Service Licens	Removal from State	trris	natory or other pla DN FOR Name and Addre	EST 02-	BROWN	) JR	2. FUN	ILS, KDZILIT ERAL HOME MD. 21217
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line.  a. ACUTE  Due to (or as a consequence)	ORO			*	rrest,		Approximate Interval Between Onset and Death
1760,	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	b. Due to (or as a consequ	ence of):	Mellitu	\$				
.O. Box 68	death certific e attending pl d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	déath 3	Ectopic pregnanc	у			23d. Date of dei Month	livery Day Year
Δ.	sign sign d be	by	Part II. Other significant conditions co	ntributing to death but not resu	•	, , ,					the cause of death?
of Vital Records,		Completed	Dementia					24a. Was auto perfo 1 🗌 Yes		prior to death?	utopsy findings available completion of cause of
ion of Vita	Attending Physician: Th r death. sctor: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	R/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 Nursing	eath (Check only of Home 5 Resident Res	idence (		city)
Division	To the Hospital or Attentiviting 24 hours after deatl To the Funeral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	) 			City or To	wn, State	)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directonpletely filled in by	ledical	(Check only 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death on and/or inv	restigation, in my	opinion, death occ	e, and due to the curred at the time,	date and	f place, and due	to the cause(s)
)	T To with	Σ	29b. Signature and title of certifier			29c. Licens	9085		Fel	te signed (Monti	2004
	Sta	te_	30. Name and address of person who con ALLANT, CHIRL 31. Date filed (Month, Day, Year)	ompleted cause of death (Item 205 M, D, 50 82. Registrar's Signati	23a) (Type, 310 0 ure	Print) LOCT.	RD. Su	ITE 201,	RAND	AUSTOUR	2004 NMD 21133
	Regist		EER 11 20	OA Arena de	1 As	ente!					

			For State Registrar	State of Mary		rtment of Hea		ntal Hygien	4004	04014
	S.,		Decedent's Name (First, Middle, L.)	.ast)				. Date of Death		3. Time of Death
	Physicia	~	Dorothy Louise	Homens			F	Month Da	6 2004	8:30A M
>	/Medic Examin	_	4a. Facility Name (If not institution, g			4b. City, Town, or Loca	ation of Death	40	c. County of Death	<del></del>
			1 Summit Court				sville		Baltin	
	Funeral Director		214-20-9431	. Sex 7. Age (III	n yrs. last birthday) 78 Yrs.		ours Min.	Date of Birth (Month, Day, Year ec. 25, 1	9. Birthp Cour Man	lace (State or Foreign ryland
	pur A		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation			1	0d. Inside City Limits
	Aanyla f eho	ō	MD Pol	Ltimore		Catonsvill	۵			1 Yes 2 No
	the the 288-	Director	MD Ba.	LUMOTE		10f. Zip Code		10g. C	itizen of What Cour	ntry?
	3a or		1 Summit Court,	Apt Al		212	28	Un	ited Stat	tes
	death me 2	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Vas Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Specif	y Yes or No-	14. Race - Americ Black, White,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ODEs.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏹 Divorced				pecify:	321, 0(0.)		Vhite
5	72 ho	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	lent's Usual Occupation kind of work done during	n g most of working	16b. I	Kind of Business/In	dustry
2	Athin	Jd I	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)		Do	yroll Dej	artment
2	led w tygier her th		12. 17. Father's Name (First, Middle, La	ct)		Secretary	Mother's Name /	First, Middle, Maide		partillent
and	i be fi ntal F ed ot	Be	Charles Walter					izabeth S		
2	hould d Me mark matic	은	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street and I				(Code)
₹	nd 2 s lith an lith an 27 is		Edna C. Shriver	Sister		Delaware A				
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Dat		Location - City or To	
Baltimore,	Page ent o nt: If ry or		1 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		Meadowric Memoria	ige or other place) al Park	2-10-	2004 E1k	ridge, M	D
ati	permit. Departm Importe any inju		21. Signatura of Funeral Service U	emore the	The second secon	. Name and Address of	The second secon	The second second second		
m	9 5 5 6		1 Dul Drus	MUDIC		328 Sulphur			itus, MD	21227
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the by one cause an each line.	e death. Our ot ente	er the of dying, su	uch as cardiac or r	espiratory arrest,		Approximate Interval Between
	Physician	8 9	Immediate Cause (Final disease or condition	SMA	hh CE	L CARC	NohA	OF hu	NO-	Tiset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
	Lxammer	-	Sequentially list conditions,	b. Due to (or as a c	onsequence of):					
_	ed Isit	al le	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to to as a ci	onsequence or,					
-	ate be executed hysician and the burial-transit	Examine	that initiated events resulting in death) Last	c	onsequence of):					
8760,	siciar buria	dical E		d						
89	ificate g phy as the	ed								
Вох	death certific e attending p ed for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1☐Live birth 2 [		Ectopic pregnancy			23d. Date of delive	,
œ.	deati	icla	in the past 12 months? 1 □ Yes 2 XNo	4☐Pregnant at tim		Other (specify)			Month	Day Year
P.O.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Me	9 □ Unknowh							4
Ś	signed d be det		Part II. Other significant conditions	s contributing to death but n	ot resulting in the u	nderlying cause given in	Part I.	J.	use contribute to the contribu	ne cause of death?
ord	w requir been si should	Completed						TIZI PAIS		
ec	alaw nasb e2sh	nple						24a. Was an autopsy performed?	24b. Were auto	psy findings available mpletion of cause of
田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田		ပို						1 Yes 2 N	death?	2 No
Ĭ Ž	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (			
o	Phys r this ral di	- L	1 Yes 250 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien	IL SLI DOA	4 Nursing Home	d. Describe how inju	6 ☐Other (Specifier occurred)	y)
Division of Vital Record	I or Attending Phatter death. Director: Atter the in by the funeral	ertiflcation:	Natural 5 Pending Accident investigation	(Month, Day Y	eer) Injury	Work?	2 🗆 No			
/isi	Atten r deat octor: y the	flea	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Injury	- At home, farm, str	eet, factory, office	28	f. Location (Street a	and Number or Rura	al Route Number,
ă	al or A s after of Direct	Cert	4 Homicide	building, etc. (	<i>ървспу)</i>			City or Town, Sta.	( <del>0</del> )	
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical (		Physician: To the est of manufacturer: On the basis of ex						
	To the h within 2 To the F complete	Med	dne)	and man er	1.	29c. License nui	mhor	- 29d D	ate signed (Month,	Day Year)
	To To	-	29 Signature and title of certifier		1.	290. License nui	01119	J.	are sidilar (Moulu)	O 5001
,	1		Hang		M. MD	1000	17411	TEI	BRUMRY	7,000
	1)	1	3 Name and address of , ⇒rson w	inpleted cause of deat	л (Item 23a) (Туре,	Print) ATOD	H12+2	Hans.	MADE D	1 2009
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	11100	1106.	MAIN	1000	1001001
	Regist		FFD 4 4 200	A freezeway	1/2	Ana st. 1	3,			
DH	HMH 17 Rev 1/2	001	- FRI 1 490	1	1	57 5 2 5 16 5 1 J				

ORIGINAL

			For State Registrar	State of Maryla		ent of Health and ate of Death		ene 2001	04015
	* = . W.		Decedent's Name (First, Middle, Las	7)			2. Date of Death	1	3. Time of Death
4	Physici /Medic		IORRIN	WALTER	HARR	15 JR.	Month	Day Year	05:10AM
	Examir		4a. Fecility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of Dea		4c. County of Deat	
			UNION MEMOR	LIAL HOS	PITAL	BALTI	MORE	N	1A.
	Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs	S / / Mont	der 1 Year If Under 24 Hr hs Days Hours Mir		Year) 9. Birt	hplace (State or Foreign untry)
Н	Director		Usual Residence of Decedent	¥23.	34 Yrs.		JULY 4	1969 MA	PRYLAND
	and and		10a. State 10b. County	10c. C	city, Town or Location		• /		10d. Inside City Limits
	Mary f sh	ō	MADILIAMA A	12	PA	ITIMODE	2 11. 71	/	1 ☐ Yes 2 ☐ No
	28a	Director	10e. Street and Number	///	101.	Zip Code	10	g. Citizen of What Co	untry?
	3a o	0	1306 MAN	TIE STEE	CET	2120	34	11.5	A
	72 hours after deeth with the Maryland natural', or tems 23a or 28a-1 show deal Examilied at	Funeral	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. Was De	cedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	
9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		~	nto Hican, etc.)	Btack, White	e, etc.
93	ours rail,	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	TLJ fe:	s 2/ No Specify:		Specify:	LACK
21215-0036	72 h natu	Completed	15. Decedent's Edi (Specify only highest grad		16a. Decedent's U (Give kind of	work done during most of we	orking 1	6b. Kind of Business/	ndustry
121	within ene. then	du	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. DO NO	Tuse retired)	,	-1- 0-	-111000
	Hygie ther t		17. Father's Name (First, Middle, Last)		DES	R CLERK	ame (First, Middle, M		EN HOUSE
and	ntal hed of	Be	1000,111	) Har	RR15	P. Mother's IVE	une (riisi, middie, m — , i	alden Sumame)	
Maryland	thoulk ad Me mark matic	၉	19a. Informant's Name/Relationship (T			ess (Street and Number or F	Pural Pouto Number	City or Town State 2	In Code)
Z	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryian Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-1 show any injury or other traumatic event, Ite Marical Examiner must be mutilised an once.		BUTH HODDIS	MATHER	1701	MANTIES	T BALL	ony or rown, state, 2	7,0311
Ē,	s 1 ar		20a. Method of Disposition		Place of Disposition (I	Name of	Date 2	Oc. Location - City or	Fown, State
OE.	Pages ent of nt: If I		1 Burial 2 Cremation 3 1 '4 Donation 5 Other (Specify,	removal from State	cemetery, crematory of	1 11	-14-04 1	BALTIMOR	or lea
Baltimore,	permit. Page Department important: If eny injury of once.	11	21. Signature of Funeral Service Literal		RBUTUS 22. Name	and Address of Vacility		TR. FUNE	
ă	Department Department Impo		) (XX)	11(n	30,8	SEPH EX	TON AVE.	RAITE	WAL STOME
7			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea	th. Do not enter the n	node of dying, such as cardia		1 / / /	Approximate
	Physician		Immediate Cause (Final disease or condition	C . 11	50-14				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):	N			9420
	Examiner		Sequentially list conditions,	(1) OV 500		besch			years
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):				3
	ecute and -trans	cam	Cause (Disease or intury that initiated events resulting in death) Last	c					
8760,	cate be executed obysician and the burial-transit	田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田		Due to (or as a consec	quence or):				
		dlcal	•	d					
9 X	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancv			221 Days of 44	
Вох	atter f for u	clar	in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3 □Ectopic			23d. Date of delin	∕ery Day Year
0	that the de ned by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
σ.	The law requires that the death certifi lie has been signed by the attending r sage 2 should be detached for use as	by PI	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w requires that been signed be should be det	Pa			-		1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
000	s bee	Completed					24a. Was an	24b. Were aut	opsy findings available
m	The law cete has page 2 s	E					autopsy performe	death?	ompletion of cause of 2 1 No
ita	ysiclan: Th	BeC	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		25 140
<u>~</u>	S S D	2	1 □ Yes 25 No	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residen	ce 6 ☐Other (Spec	fy)
u	ding Ph. After thi funeral		27. Manner of Death  1 Setural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Intury	28c. Injury at Work?	28d. Describe how	injury occurred	
<u>sio</u>	ten leat for: the	cat	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Attendation of the Director:	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fact fy)	ory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
-	pital ours a eral I		29a. Certifier To Certifying Phy	laine. To the beat of an in-	- de				
	P Hos	edical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or investigati	ed at the time, date and place on, in my opinion, death occi	e, and due to the cau urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	/ ,	2	29c. License number	290	I. Date signed (Month,	Day, Year)
)			1 / h	new MD		A7743	8746 Fe	Sman 10	20157
	1		30. Name and address of person who co	, ,	1	ATJ43 Unio n Me			
			Peter Kushi		medicine	Uneo in the	your H	14 gar	
	Sta Registra		31. Date filed (Month, Day, Year)	32, Registrar's Signa	ature Acade to				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

				ificate of			giene Reg. No.	04	0.506
	Physic /Medi		111.11.03			2. Date of De Month	eth Day	Year 04	3. Time of Death
100	Exami		4- 5- 30- 84 - 46 - 41 - 45 - 41 - 41 - 41 - 41 - 41 - 41	4	4b. City, Town, or Lo Largo	cation of Death	4c. County		ego!c
	Funeral Director		245-48-0739 1□M 2X F 72 Yrs. N	If Under 1 Year Months Days		8. Date of Bir (Month, Da Sept 2	th y, Year) 0, 1931	9. Birthplac Country North	ce (State or Foreign Carolina
	Maryland 1-1 show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat  MD Prince George's Largo						I. Inside City Limits 1 ☐ Yes 2 ☐ No
	ter death with the Marylan Items 23a or 28a-f show Inst. Pust be notified at	al Director	10e. Street and Number 600 Largo Road	10f. Zip Code	7 /1		10g. Citizen of		?
020	within 72 hours after death with the Maryland ena. than "natural", or Items 23a or 28a-f show he Medical Enaminer must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Year or Dates:		ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)		ce - American ck, White, etc	<b>.</b>
Maryland 21215-0020	permit. Pagas 1 and 2 should be filed within 72 hours at Depertment of Health and Mantel Hygiena. Important: if item 27 is marked other than "natural", or any figury or other traumatic event, the Medical Enginena.	Completed	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  unk  16a. Decedent (Give kinc) iife. DO  unk	nt's Usual Occupa nd of work done of NOT use retired	ation Ju <i>ring m</i> ost of workir I)	ng unk	16b. Kind of B	usiness/Indus	stry unk
yland	ould be filed Mantel Hyg arked other atic event	To Be C	Oscar Lee McCoy		18. Mother's Name	Cecily	Smith		
e, Mar	l and 2 sh Health and m 27 is m her traum		Robert K. Hooker/spouse 3010	Largo R	and Number or Rura Load Upper			State, Zip Co 20772	_
Baltimore,	tt. Pagas rtmant of H rtant: if ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	on (Name of ory or other place	θ)	Date	20c. Location -	City or Town	, State
Ba	Depe Impo		Rolland S. Wade, Director Sta	timore,	omy Board MD 21201			ore St	reet
1	Physician /Medical	Î	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one ceuse on each line.  Immediate Cause (Final disease or condition Pneumonia	he mode of dying	g, such as cardiac or	respiretory an	rest,	Int	oproximate tervel Between nset and Death
	Examiner	er	disease or condition resulting in death)  Due to (or es a consequen dementia alzheimer					1	days
<b>~</b>	axecuted n and ial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury						yrs
Box 68760,	law requires that the death certificate be asscuted as been signed by the attending physician and 2 should be detached for use as the burial-transit	n/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	ce of):					
P.O. Bo	it tha death by the attar tached for u	Physiclan/	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause give	n in Part I.				e cause of death?
ords, I	v requires that tha death ce been signed by the attandir should be datached for use	2	diabetes mellitus type 2			24a. Was a	n eutopsy	24b. Were e	eutopsy findings ole prior to
I	Tha ata h page	Completed				1 □ Y	es 20 No	of deat	etion of cause th? es 2□ No
	ystcie is certi diracto	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Othor	26. Place of Death			r (Specify)	
O HOISINIO		Certification:	27. Manner of Death  1 Naturel 5 Pending (Month, Dey Year)  2 Accident investigation	28c. Injury Work			w injury occurre		
	oltal or Att urs efter d aral Direct illed in by		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, full building, etc. (Specify)			City or Towr			
	the Host in 24 ho the Fune	edical	29a. Certifier (Check only one)  1 ✓ Certifying Physiclen: To the best of my knowledge, death occurrence on the basis of examination and/or investige and manner stated.	curred at the time gation, in my opi	e, date end place, en nion, death occurred	d due to the ce l at the time, da	ouse(s) and mer ate and place, a	nner as stated nd due to the	1. cause(s)
)	Verit Con	Σ	29b. Signature and title of certifier	29c. License	number 7 2 6 i		9d. Date signed		Yeer)
	`		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n Apris	N A-4	CAN	han m	7 20	706
ı	Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Cichmy J. Color M. G. D. A.	2	,	).			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] State Registrar Amend Item#17perFHG828 2/11/04 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day\_ 1750 P Physician 2004 HOOPER B. HILTON Februar y /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9319 Kilbride Ct. Baltimore County Baltimore 8. Date of Birth (Month, Day, Year) Sent. 27,1935 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 10X M 2□F Days 218-32-0175 68 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner coust be notified at Maryland Baltimore 1 ☐ Yes 2 XNo Baltimore County Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a 9319 Kilbride Ct. 21128 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2(1) No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ¥ Widowed 4 □ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s f and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Real Estate Appraiser Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John William Hilton, Sr. (Brother) Mildred R. Bohanon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Hilton, Jr.(Brother) 1120 Vernon Avenue Baltimore, Maryland Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 E 1 ☐ Burial XX Cremation 3 ☐ Removal from State Important: I eny injury o gnce. Metro Crematory Inc. 2-9-04 Baltimore. Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Arterioscleratic Cardiovascular Disease Physician 10 Hars resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner tran and Due to (or as a consequence of) -burialattending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day signed by the al 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 ☐ Yes rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) ¥Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b Signature and title of sertifie 29c. License number 29d. Date signed (Month, Day, Year, 866 rebruary completed cause of death (Item 23a) (Type, Print) Militello 6 vrimble Hill CT. Lather Wille 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

2004

			State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  John A. Hutchi.u's  2. Date of Death Month Day Yeer 1500  Feb 8 2004 1500	М
	Examin Funeral		4b. City, Town, or Location of Death  A DIVE A VUNDER OF A Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days Hours Min. (Month, Day, Year)  9. Birthplace (State or Fore Country)	ign
	Director		214-38-8779  12M 2 F 69 Yrs. Months Days Hours Min. (Month, Day, Year) Country, Maryland  Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	ils
	he Maryla 18e-f shor culfied si	Director	MD Anne Arunde1 Gambrills 1 □ Yes 2 ☑ Yes 2 ☑ 1 □ Yes 2 ☑	
	Sa or 3	١	1693 Justin Drive 21054 USA	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If term 27 is marked other then "natural", or items 23a or 28e-f show important: If term 27 is marked other then "natural", or items 25a or 28e-f show any injury or other treumatic event, Ite Medical Examinar must be notified at once.	by Funerai	11. Marital Status  1	
21215-0036	within 72 hou ane. then "natura or Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+  Counselor  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Education	
ў Д	filed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
/lan	Mental Mental Mrked Milc ev	To B	John Albert Hutchins Catherine Waters	
Maryland	d 2 sho		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Victoria J. Hutchins (Wife)  1693 Justin Drive, Gambrills, MD 21054	
Je,	s 1 an if Heal item 2 other		20a. Method of Disposition  20b. Place of Disposition (Name of Computery Computer Compu	_
Baltimore,	Page ment c tent: If jury or	١.,	'4 Donation 5 Other (Specify) Metro Crematory 2/12/2004 Baltimore, MD	
Ball	Departit Depart Impor any in		21. Signature of Funeral Serve Licented  22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401	
	Pnysician /Medical	i yi	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death Cause (Final disease)	
	Examiner		Due to (or as a consequence of):	
8760, /	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, reading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Oue to (or as a consequence of):  C. Due to (or as a consequence of):	
	rtificate ng phys as the	Medic		-
P.O. Box	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
rds, P.	w requires that been signed by should be deta	<u>م</u>	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Dithknown	wn
		Completed	24a. Was an autopsy findings availal prior to completion of cause of death?  1 ☐ Yes 2 ☐ M6 1 ☐ Yes 2 ☐ No	ole of
Vita	reicien: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1	_
ion of	fter	atlon: To	27. Manner of Death 1 Xolatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	
Divis	iel or Atte s after de al Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
<b>)</b>	To t To t	Σ	(Check only and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Marge and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Pegistrar's Signature  33. Pegistrar's Signature  34. Pegistrar's Signature	
	9		30. Marge and address of person who completed cause of death (Item 23a) (Type, Print)  William P. Jones, MD 695 America 21035	
	Sta Regista		51. Date filed (Month, Day, Year)  FEB 11 2004  32. Pegistrar's Signature	

			For State RegistraMEND ITEM #17	State of Maryland PER FH G828 2/25/0					jiene	004	04019
	***		Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physicia		Lula Beatrice Heno	ion				Month Februar	Day	Year 2004	3:20 PM M
}	/Medic Examin		4e. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			ounty of Death	
			Ivy Hall Nursing (	Geriatric Cente	er	В	alitmore		Bal	timore	
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	olace (State or Foreign ntry)
	Director		215-12-1412	8	7 Yrs.			Jan 1,	1917		
	w w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Aaryli f sho	៦	ND D 311	- 7							1 □Yes 2 No
	the A	Director	MD Baltimor  10e. Street and Number	e l Balt	imore	10f, Zip Code		1	0g. Citize	on of What Cou	ntry?
	with 3a or		2 111- 01	2							-
	death ms 2:	Funerai	3 Haylock Ct. # 20	12. Was Decedent Ever in U.S.	13. \	21236 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe			ed Stat . Race - Ameri	can Indian,
21215-0036	be filed within 72 hours after death with the Maryland lat hygiene. Id other than "naturel", or items 23s or 28e-f show event, the Madical Extrainer must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Hican, etc.)	S	Black, White,	
ŏ	2 hou	ed	15. Decedent's Edu	cation	16a. Deced	tent's Usual Occupa	ition		16b. Kind	White of Business/In	
75	within 72 ene. than "nai	Completed	(Specify only highest grad	College (1-4or 5+)	life. (	kind of work done d OO NOT use retired,	lu <i>ring</i> most of worki )	-	Foods	store	
2	d with giene.	ĕ	1.2		Cashi	er	· · · · · · · · · · · · · · · · · · ·				
	be filed v tal Hygie d other i	Be (	17. Father's Name (First, Middle, Last) OSCAR EDWIN REICHHARD	Т			18. Mother's Name	(First, Middle,	Maiden Su	u <i>m</i> ame)	
<u>a</u>	should be nd Mental marked o	2	Oscar Edwin Reick				Alice Eve	elyn McC	lell	and	
Maryland	2 sho and is m		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailin	ng Address (Street a	and Number or Rura	al Route Number	, City or T	Town, State, Zip	Code)
	permit. Pages I and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic events.		Karen E. Morris/Da	ughter	3 Нау	lock Ct.	# 203, 5	altimore	111	21236	
Baltimore,	ges 1 of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	can	ce of Dispo netery, cren	sition (Name of natory or other place	9)		20c. Loca	ation - City or To	own, State
Ë	Pagiment ment tent: jury		* 4 ☐ Donation 5 ☐ Other (Specify)	Che	sapea!	ke Gremat	orvi 2	eb 11	Belts	ville,	MD
Sali	permit Depar Impor Impor Iny in		21. Signature of Fuperal Service Licens			. Name and Addres Cremation	1417	mal Alt.	- mn - +		
	70 % 4 Q		23a. Part1. Enter the disease, or compl	ann M00382						lives Ltimor	MD
Н			shock, or heart failure. List only o	ne cause on each line.		_	-				Approximate Interval Between Onset and Death
	Physician	4	Immediate Cause (Final disease or condition resulting in death)	Recuve	ent	Durde	L hon	Mosis			3-4 w/0
1	/Medical Examiner		resulting in dealin)	Due to (or as a conseque	nce of):	Durde	and k	Julie .			un-Knaon
п		ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque		u (b)	cove a 1	- fine			
Τ	red	n in	cause. Enter Underlying Cause (Diseese or injury that initiated events	(	,						
_,	icate be executed physicien and the burial-transit	Examin	resulting in death) Last	Due to (or as a conseque	nce of):						
38760,	e be sicie e bur	dical		d							
89		•							-,	1_	
Вох	death certifi attending p	M/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnand		Testania pragnana			230	d. Date of delive	ery
œ.	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dee	_	Ectopic pregnancy Other (specify)				Month	Day Year
P.O.	by the	hys	9 Unknown								
	ss the	by F	Part II. Other significant conditions con		ing in the ur	0.5					he cause of death?
ğ	w require been sign		HINI	o chemic	Gr	alony	oparry.	1 □ Ye	es 2 □ 1	No 3 ☐ Prob	pably 4 Honknown
900	has be ge 2 sh	Completed	Demen	tia. Chro	nic_	Mound	whan	24a. Was a autops		24b. Were auto	psy findings available mpletion of cause of
Ě	he h	Ĕ						perform 1 ☐ Yes	ned?	death? 1 ☐ Yes	
ita	ician: T certificat rector, p	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only on	e)		
<u>~</u>	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ᠿ No	lospital: 1 ☐ Inpatient 2 ☐ El	NOutpatien		4   Nursing no	me 5□Reside	ence 6	□Other (Specif	<b>y</b> )
0	ng Pl		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury o	occurred	
sio	tendi eath. or: A	cati	2 ☐ Accident investigation				res 2 □No				
Division of Vital Records,	el or At after d I Direct d in by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St City or Town		Number or Aura	al Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical C		sician: To the best of my knowl ner: On the basis of examinatio and manner stated.							
	To the Ho within 24   To the Fu completel	Mec	29b. Signature and title of certifier	and mainter stated.		29c. License	number	2		signed (Month,	
	h-		> Also M.D				38754				2004
			7717	ASBEM.	709.	BAST	ARN B	LVD,	M	D - 2	1221
Sec	Sta Registr		31. Date filed (Month, Day, Year)  FFB 1 1 200	32. Registrar's Signatu	4	20/2					
			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		all all						

DHMH 17 Rev 1/2001

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 4:10 PMM (NMN) Higgins February 8. 2004 Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Cecil Laurelwood Nursing & Rehabilitation If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months 93 Director 293-01-0325 Sept. 5, 1910 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6184 Telegraph Road 21921 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 □ Divorced ear or Dates: White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induetry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 0il Company 10 Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental H Barbara (NMN) Schubert 2 Frank (NMN) Nesval 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is it any injury or other treum 2006. Karen Rice/daughter 6184 Telegraph Road, Elkton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Garden 2/12/04 Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Sign Yury of Funeral, Service Kicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death ereprovazcular Immediate Cause (E/nal disease or condition accident Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No ate has been signed by the atte page 2 should be detached for Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, KzNo INI 20 No 3 Probably 4 □Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 2 3□ DOA ursing Home 5 Residence 6 Other (Specify) After this funeral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 V0056698 FEBRUARY my MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M WILMINGTON, DELAWARE 19811 LOVERING AVE. 10-C MO STAISAL SIZAS 1100 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 2004 FFB<sub>1</sub> Registrar

			1 - State Registrar		epartment of Health and M Certificate of Death	fental Hygier Reg. i	_ ZUUU
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	, 1	1mmonds	2. Date of Death Month	Day Yeer 3. Time of Death 18 2004 03.45 M
)	Examin		4a. Facility Name (If not institution, give s Howard County Co		4b. City, Town, or Location of Death		4c. County of Death  LOWARD
	Funeral Director		5. Social Security Number 5. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min. ZD	8. Date of Birth (Month, Day, Yea JAn - 18	9. Birthplace (State or Foreign Country)
	iryland show	_	Usual Residence of Decedent  10a. State 10b. County  MD Howard	10c. City, Town			10d. Inside City Limits
	th the Ma or 28e-f s	Irecto	10e. Street and Number	Colu	10f. Zip Code	10g. (	1 ☐ Yes 2∑ No  Citizen of What Country?
	n 72 hours after death with the Maryland "neturel", or tlems 23a or 28e-f show calcal Executing reast be neithed at	Funeral Director	7210 A Eden Brook		21046  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.
0000	ours after irel', or lu Exercition	ξ	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specity:		Specify: White
7 2	C 39	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) ((	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Industry
7 DU	s 1 and 2 should be filed within I Health and Mental Hygiene. Item 27 is marked other than " other treumatic event, II a Me	Be	17. Father's Name (First, Middle, Last)	11 /-		e (First, Middle, Maid	111
Maryie	12 should be n and Mental 7 is marked o reumatic ev	ဥ	19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. N	Mailing Address (Street and Number or Run	al Route Number, City	
ore, i	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 R	emoval from State cemetery,	crematory or other place)	. 1	Location - City or Town, State
Santin	permit. Pages 1 and Department of Heall Importent: If Item 2 any injury or other any ince.		*4 □ Donation 5 ☑ Other (Specify)  21. Signature of Farmaral Service License		22 Name and Address of Facility		altimore Street
	405 6 0		23a. Part Enter the disease, of compli- shock, or heart failure. List only on	cations that caused the death. Do not be cause on each line.	Baltimore, MD 2120 tenter the mode of dying, such as cardiac	) 1 or respiratory arrest,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	<del></del>		Onset and Death
L		Iner	Sequentially list conditions, harry, leading to himidate cause. Enter Underlying Cause (Disease or injury	Dire to (or se a consequence of	pl.		
,00/	icate be executed physician and s the burial-transit	I Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequence of)	):		
		Medical	IF FEMALE:				
J. DOX	w requires that the death certif been signed by the attending should be detached for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
, F.	res that th signed by be detacl	by	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to the cause of death?
ecords,	law requi	Completed				24a. Was an autopsy	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of
	zien: The artificate h ctor, page	Be Con	25. Was case referred to medical examiner?		26. Place of Deat	performed? 1 ☐ Yes 2 ☐X\ n (Check only one)	
5	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ဥ	1 ☐ Yes 2 ☑ No H  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	lospital: 1 ☑ Inpatient 2 ☐ ER/Outp  28a. Date of Injury (Month, Day Year)  28b. Tin	ne of 28c. Injury at work?	me 5 Residence 28d. Describe how in	6 ☐Other (Specify) jury occurred
IVISION	or Attendi ter death. irector: A n by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No n, street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ate)
ב	Hospital of the hours all Eunerel Dely filled in	edical Ce	(Check only 2 Medical Exemin	ner: On the basis of examination and/	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the causered at the time, date a	(s) and manner as stated. Individual place, and due to the cause(s)
	To the within 2 To the complete	Med	one)  29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
			30. Name and address of person who co	/	) 002911-1 ype, Print) 2 111	C+ 11-1	an 18, 2004 Clarksville, ND 21029
	Sta	te	31. Date filed (Month, Day, Year)	SM.D 5005 Sm. 32. Registrar's Signature	ignal Dell LAME	31.102 (	LIARKSUIK, MD 21029

			For State Registrar	State of Maryland	d / Departi Certif	ment of He	alth and M eath		ene 200	4 04023
>	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Aa. Fecility Name (If not institution, give	Catherin.	e E. la	City, Town, or Lo		2. Date of Death Month Penruar	Day Yeer	44
	Funeral Director		217-16-7534	00. /			f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 29,		thplace (State or Foreign ountry) ryland
	e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Aru		Town or Locati	l				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other then "netural", or itams 23e or 28e-f show or other traumatic event, the Medical Example at must be collised at	Funeral Directo	10e. Street and Number 396 Centerhill Aver 11. Marital Status	112. Was Decedent Ever in U.S Armed Forces?	6.   13. Was	Of. Zip Code 21090  Decedent of Hisps, specify Cuban,	anic Origin? (Spe Mexican, Puerto	U ecify Yes or No-	n. Citizen of What C Inited Sta 14. Race - Am Black, Whi	ates erican Indian,
-0036	2 hours after etural', or its	by	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced  15. Decedent's Edu	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 a. Decedent	Yes 2X No	Specify:	16	Specify:	White
d 21215-0036	filed within 7: Hyglene. ether then *n	e Completed	(Specify only highest grade  Elementary/Secondary (0-12)  6  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO	of work done dur NOT use retired)  Control	Clerk		insurance	Company
Maryland	2 should be and Mental le marked o	To B	Charles Hommerbocke	pe, Print)		ddress (Street and		al Route Number, C	City or Town, State, IM, Maryla	
altimore, N	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		William E. King, Jr  20a. Method of Disposition  15 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. Pla	ace of Disposition	n (Name of ry or other place)	[	Date 20	oc. Location - City of altimore,	Town, State
Balti	permit. Pages Department of Important: If I eny injury or one		21. Signature of Funeral Service kicens	sink	410	7 Wilker	ns Avenu	e, Baltim		Inc. yland 21229
	Fnysician /Medical Examiner		23a. Pert1. Enter the disease, of complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	ry Ar	tery		ase		Interval Between Onset and Death
8760,	ite be executed sysician and ne burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.	1 4	arny				yeary
O. Box 6	death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 monus? 1 □ Yes 2 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ect	opic pregnancy ner (specify)			23d. Date of de Month	livery Day Year
ords, P.	law requires that the as been signed by the 2 should be detache	by	Part II. Other significent conditions con	ŧ	lting in the under	lying cause given	in Part I.			o the cause of death?
Vital Records,	The lar ate has page 2	e Completed	25. Was case referred to medical	7 UN			S Place of Death	24a. Was an autopsy performe 1 Yes 2	prior to	utopsy findings available completion of cause of s 2 No
o	ling Phys n. After this funeral dir	To B	examiner?	1  Inpatient 2 E 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other: 28c. Injury a Work?	Nursing Ho		ce 6 Other (Spe	acify)
Division	i Die	i Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	)			City or Town,		
	To the Hospitel within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my know ner: On the basis of examinati and manner stated.	viedge, death oc on and/or invest	gation, in my opin	ion, death occurr	ed at the time, date	se(s) and manner a e and place, and du I. Date signed (Mon	th, Day, Year)
•	0		30. Name and address of person who was a state of the sta	mpleted cause of death (Item	23a) (Type, Prin		altima	re Mo	ebricar wylemd	y 6, 2004 21227
	Sta Registr	•	31. Date fied (Month, Day, Year) FEB 1	32. Registrar's Signati		Board à		, - , • •	1	-1-/

			For State Registrar	State of Ma		/ Depa		of He	alth a			giene 2	004	04024
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Vaar	3. Time of Death
	Physicia /Medic		JOHN GEORGE I	KOVACH							Februa	ry 9,	2004	5:35 P <sup>M</sup>
	Examin		4a. Fecility Name (If not institution,	give street and number)			4b. City, To	wn, or L	ocation o	f Death			nty of Deeth	
		y.	HOSPICE OF BALT					Cows		0411				County
5	Funeral		5. Social Security Number 207-05-5614	S.Sex 7.Age 1527M 2□F	e (In yrs. Ia. 85	st birthday) Yrs.	If Under 1 \ Months D	ays	Hours Hours	Min.	8. Date of Birt (Month, Da Apr 16	h γ, Year) 1010	9. Birthp	olace (State or Foreign otry) sylvania
P M	Director		Usual Residence of Decedent	21	- 05						Apr 10	, 1910	remi	Sylvalita
35	Maryland -f ehow lised at		10a. State 10b. County		10c. City,	Town or Lo							1	0d. Inside City Limits
m. *	a-fel	ctor	Maryland Baltim	ore County		To	wson							1 ☐ Yes 2 No
R	ith the or 28a	Oire	10e. Street and Number				10f. Zip Co		0.1			10g. Citizen o		ntry?
t	death with ms 23a or	ra	1055 W. Joppa		5 '- U O	148.3	M - D 1 -	212		-:-0 /0	of Was as No		USA	an Indian
_9-9- 036		by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? d 1 X Yes 2 ☐ N If Yes, Give Year or Dates:		5-'46	was Decedent f Yes, specify	Cuban,	Specify:	gin / (Spec i, Puerto F	ofy Yes or No lican, etc.)		lack, White,	etc.
2-9 5-0036	2 hou	ted	15. Decedent's	Education		16a. Deced	ient's Usual C	Occupat	ion	t of working	g	16b. Kind of	Business/In	dustry
7.	C _ 2	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-	i+)	lite. I	kind of work o	retired)	iring most	OF WORKIN	g	Inves	tment	
-7 6	filed withir Hygiene. other then	် ပ		5+		Gener	al Par			In Manage	(F)	Bank		
NHOP (	s 1 and 2 should be filed within the the thank and who that the the tendent other them other traumatic event, the M	Be	17. Father's Name (First, Middle, La		Kovad	ah		'			(First, Middle,		mba	
	2 should be and Mental	2	Michael  19a. Informant's Name/Relationshi		KUVat		ng Address /S	Street ar	Mar:		Route Numbe			Code)
7 2	d 2 s ith an 27 io trau		Mrs. Helen P. Ko		e)		•							and 21204
士	s 1 and 1 tem Stand		20a. Method of Disposition	/	20b. Pla	ce of Dispo	sition (Name natory or othe	of			ate		n - City or To	
	Pages ent of nt: If		1 X Burial 2 ☐ Cremation 3 1  Donation 5 ☐ Other (Specific Specific Speci			•	-		1	ns 2	/12/20	4 Time	nium.	Maryland
KOVACH Baltimore	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is eny injury or other tra gnce.		21. Signature of Funeral Service	consde		22	. Name and	Address	of Facilit	у				
0 "	88558		Martin D. L	awson		1 6	500 Ye	ork	Road	. Ral	timore	, Mary	1and 2	1212
X			Martin D. I.a. 23a. Part1. Enter the disease, or canock, or heart failure. List o	omplications that caused nly one cause on each lin	the death. ne.	Do not ent	er the mode o	of dying,	, such as	cardiac or	respiratory a	rest,	Association	Approximate Interval Between Onset and Death
	Physician		disease or condition	_a Me	tast	atic	eso	pho	age	9	Cano	er		Years
	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):								/
- 1		<u>ا</u>	Sequentially list conditions,	b. Due to (or as a	a conseque	ance of):								
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
_	ite be executed sysicien and ne burial-transit	Exa	resulting in death) Last	Due to (or as a	a conseque	ence of):								
760	nte be nysicie	ical	•	d										
89	leath certificate t attending physic	Physician/Med	IF FEMALE:											
ă	ath ce	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal	déath 3 🗆	Ectopic preg						Date of delive Month	ery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5L	Other (speci	:rfy)						
0	that the deled by the detached		Part II. Other significent condition	s contributing to death bu	ut not resul	lting in the u	nderlying cau	se giver	n in Part I.		23e. Did t	obacco use co	ontribute to the	he cause of death?
7	uires sign Id be	d by									10	res 2 No	3 🗆 Prot	oably 4 DUnknown
ç	Attending Physicien: The law requires that the death certificate relath.  sctor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed						-			24a. Was	an 24	b. Were auto	opsy findings available
ď	The law	dwo									autos perfo	rmed?	prior to co death? 1 \( \text{Yes}	mpletion of cause of
C	sician: The certificate rector, pag	Be C	25. Was case referred to medical						26. Place	of Death	(Check only o			
>	Physici this ce	ToE	examiner? 1 □ Yes 2 No	Hospital: 1  Inpatie	ent 2 🗆 E	R/Outpatier	nt 3□ DOA	Other	4 □ Nu	irsing Hon	e 5 Resi	dence 6	ther (Specif	mospice
2	ding Ph After th funeral		27. Manner of √eath 1 ►Natural 5 □ Pending		ry y Year)	28b. Time o Injury		. Injury	?		8d. Describe l	now injuly occ	curred	
	Mtendi death. ctor: A y the fu	cat	2 Accident investiga 3 Suicide 6 Could no	ot be 200 Blace of Join	unu . At hos	no form str	M (actor)		es 2 🗌		9f Location /	Street and Nu	mher or Rus	al Route Number,
e Proposition of Wital Boronde	i i e i	Certification:	4 Homicide determin	building, etc	c. (Specify)	)	eer, ractory, c	SHICE		ľ	City or To		modi oi ridie	i riodio radinosi,
V	pita purs erai	caic	29a. Certifier   Certifying	Physician: To the best o	of my know	vledge, deat	h occurred at	the time	e, date an	id place, a	nd due to the	cause(s) and date and place	manner as s	itated.
	the Hos hin 24 hc the Fun	Medical	296. Signature and title of certifier	and manner sta	ated.				number			29d. Date sig		
	Tc co		250. Signature and title or continue	Q III	$\sim$		0	< 2	131	72	16	Toball	30 H	10.2000
	07		30. Name and addres of person w	no completed cause of de	leath (Item	23a) (Type	Print)	<u>ن ن</u>	/			-01-01	1.2	14 cary
	`		The address of person w	les mo	ColoC	1/10	CV	1012	دحا	St	Balt	more	MD	21204
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ure	books							7
	Regist	rar	FEB 11	2004	14.8 D	15 1	MANU!							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / De	partment o	of Health a of Death	and Mental H	lygiene	2004	04025
,	Physicia /Medic Examin	al	Decedent's Name (First, Middle,     A. Facility Name (If not institution,	PHILLIP S	STEPHEN 1		SKI wn, or Location o	2. Date of Month JANU2 of Death	ARY 2		3. Time of Death 6:02 P M
	uneral irector		131-62-8003		e (In yrs. last birthda 39 Yrs.	y) If Under 1 Y	PMINSTE Year If Under: ays Hours			ARROLL  9. Birthp Cour TENN	place (State or Foreign htty) ESSEE
the Maryland	28a-f show notified at	rector	Usual Residence of Decedent  10a. State	ROLL	10c. City, Town or WES	Location TMINST			10g Citiz	en of What Cour	1 ☑ Yes 2 ☐ No
<b>-UU36</b> hours after death with the Maryland	"natural", or Items 23a or 28a-f show edical Examiner must be notified at	y Funeral Director	79 SCHAEFFER  11. Marital Status  1 X Never Married 2 Marrie	12. Was Decedent Armed Forces?		2	1157 of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No- 1	JSA 4. Race - Americ Black, White,	ean Indian,
Within 72 ane.	than "natural", he Medical Exa	Completed by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)  1 2	Year or Dates:	(Git	edent's Usual O re kind of work d DO NOT use re		of working		d of Business/Inc	TTE dustry
Iryland Z should be filed of Mental Hyoli	marked other matic event, I	To Be Co	17. Father's Name (First, Middle, La	STEPHEN KI	Losinski		18. Mother	r's Name (First, Midd JLA ANIT r or Rural Route Nun	Maiden S A STE	Sumame) PHENS	Code
MOTE, Ma	riant: If item 27 is mar njury or other traumat		WILLIAM S. KL  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3  1 □ Donation 5 □ Other (Spe	OSINSKI-FA	ATHER 33  20b. Place of Discemetery, cr	4 E . Mi	AIN ST		INSTE 20c. Loc	R, MD. ation - City or To	21157 own, State
permit. P	Importan any injur Ores.		21. Signature of Funeral Service Li  23a. Part1. Enter the disease, or deshock, or heart failure. List or	man de la companya della companya della companya de la companya della companya de	6	$254~\mathrm{E}$ .	ddress of Facility	FLETCHE: ST., WES	R FUN IMINS		OME
ate be executed EX	nysicia he bur	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c.	. / .			OXICA			Interval Between Onset and Death
the death certificate	been signed by the attending pl should be detached for use as t	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregn: □ Other (specif)			23	3d. Date of deliver Month	ry Day Year
ecolds, F.O	been signed t	eted by P	Part II. Other significant condition	s contributing to death bu	ut not resulting in the	underlying cause	given in Part I.	1	Yes 2		e cause of death? ably 4 Unknown
VICAL THE LAW	ortificate has I	Comp	25. Was case referred to medical examiner?				26. Place	per	opsy formed? 2 \( \sum \) No	prior to con death?	osy findings available apletion of cause of
Attending Physician:	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	P _	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could no	be 28e. Place of Inju	y 28b. Time Injury	of 28c. [	niuryat Work? 1 □ Yes 2 XN	28f. Location	Street and	occurred  CD PRIVA  Number or Rural	Route Number.
To the Hospital or Attending within 24 hours after death.	e Funeral Din letely filled in t	edical Certi	29a. Certifier 1 Certifying	building, etc  Physicien: To the best of aminer: On the basis of and manner stal	of my knowledge, deal examination and/or i	Home th occurred at th	e time, date and	place, and due to the	own, State)	MINSTRI	MARFIER MO
To the within	To th compl	Σ	29b. Signature and Artis of certifier	1 m	RIPLE	Fin C	ense number			signed (Month, D	
	Stat		30. Name and address of person when the state of the stat	5 L1	111 Per	nn Stree	et, Balt	imore, Mar	ryland	21201	
	Registra	ır	31. Date filed (Month, Day, Year)	2004 32 Hegistra	US A	and .					

			1 - For State Registrar	State of I	Maryland		artment rtificate			and M	lental Hyg	giene 2	004		026
	Physici	an.	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea		Yeer	3. Time	of Death
1	Physici /Medi		Patty	Watford		K1	cause				Februa	ry 9	2004	2:00	a <sup>M</sup>
	Examir	er	4a. Fecility Name (If not institution, 420 Hamlet Clu				4b. City, To			f Death			unty of Death		
	-		5. Social Security Number		Age (In yrs. la	ast hirthday)	If Under 1	ewat	er If Under 2	24 Hrs.	8. Date of Birth		e Arun		or Foreign
	Funeral Director		216-32-3837	1□M 2∏F	68	Yrs.		Days	Hours	Min.	Nov. 3,	/, Year)	NO.	nplace (State untry) cth Can	colina
	ס		Usual Residence of Decedent										7 1101		
	arylar show	Ļ	10a. State 10b. County			, Town or La								10d. Inside (	
	he M	Director		Arunde1	Edg	gewate									2 No
	with t		10e. Street and Number				10f. Zip C					10g. Citizer	n of What Co	untry?	
	leath ns 23	by Funeral	420 Hamlet Club	12 Was Decede	nt Ever in 11.9			037	panic Orio	in? (Sp	acify Yes or No-	14.	USA Race - Amer	ican Indian	
တ	or Her	Fun	1 ☐ Never Married 2 X Marrie	Armed Force ed 1 ☐ Yes 2	\$? XNo					Puerto	ecify Yes or No- Rican, etc.)		Black, White	o, etc.	
ğ	ral', c		3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1⊡Yes XX	<u>A</u> No	Specify:			Sp	ecity: V	White	
7	within 72 hours after death with the Maryland ene. than 'natural', or items 23e or 28e-f show ha Medical Examinar must be notified at	Completed	15. Decedent' (Specify only highes			(Give	dent's Usual kind of work	done du		of worki	ing	16b. Kind	of Business/l	ndustry	
12	within	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use	,				77	1.		
р 7	filed wit Hygiene other the		17. Father's Name (First, Middle, L	.ast)		Kece	ptioni		8. Mother	r's Name	(First, Middle,		ding		-
an	ould be Mental arked o	To Be	Fred Watford	_							Elliot		,		
Maryland 21215-0036	S D E E	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (S	Street an			A Route Number		own, State, Z	ip Code) 21	037
	and 2 ealth a n 27 ls		Richard Krause	(Husband)							Apt. 3				
altimore,	ges 1 and the if Item or other		20a. Method of Disposition 1 □ Burial 2 ☒Cremation	3 Demoval from Sta	20b. Pla	ace of Dispo	sition (Name natory or oth	of er place)	1		ate	20c. Locat	ion - City or T	own, State	
Ĕ	Pages ment of ant: If Its ury or o		`4 □ Donation 5 □ Other (Sp				emator	-					more,	MD	
Ball	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	free		22	Hardes	Address.	of Facility Fune i v Ave	al l	Home, P.	A.	MD 21.	401	
1	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that cause on each	ed the death.		er the mode	of dying,	such as o					Approxima Interval Be Onset and	tween
	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	ence of):	wali	uc	(.1	VVV	31		-		
	Examiner	Ш	Sequentially list conditions	b		(	NV W	100	, 0	WA	zy dr	i ce	tras		
7	p is	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of				-	( -	, , , , ,			
/	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):									
8760	cate be executed physician and the burial-transit	dical E		1		31,03 31,1									
687	ificate g phys	edic		d											-
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnan 2  Fetal		T-1					23d	. Date of deliv	very	
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of dea		Ectopic preg Other (spec						Month	Day	Year
о. О	at the de d by the a stached	Phy	9 Unknown												
Vital Records,	The law requires that the te has been signed by the sage 2 should be detached.	by	Part II. Other significant condition	ns contributing to death	but not resul	ting in the ur	iderlying cau	se given	in Part I.				contribute to lo 3∏Pro		
000	lawre as be 2 sho	Completed									24a. Wasa		4b. Were aut		
ř		E O									autops perforr	ned?	death?	ompletion of c 2[] No	ause or
ita Ita	iician: The lav certificate has rector, page 2	Be (	25. Was case referred to medical examiner?	7				A.,		of Death	(Check only on				
0	Physician: r this certific ral director,	٥	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inpa		R/Outpatient		Other:	4 🗀 1401:		ne 5 Reside			fy)	
ב	Afte	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		ijury Da <i>y Year)</i>	28b. Time of Injury		. Injury a Work?			28d. Describe ho	ow injury oc	curred		
Division	vttendii death. ctor: A y the fu	icat	2 Accident investigated as Suicide 6 Could not	ot be 280 Place of	niury - At hon	ne farm stre	M lactory o		s 2 N		28f. Location (St	root and N	umher or Pur	n / Pouto Alua	bor
2	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune.	Certification:	4 Homicide determit	building,	etc. (Specify)	ne, rann, sue	set, ractory, c	nnce		ĺ	City or Towr	, State)	umber of Auf	ai noule ivuii	iber,
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the 1	edical	29a. Certifier 1 - Certifying (Crieck Gray 2   Medical E	Physician: To the be- xantiner: On the basis and manner	or examination	rledge, death on and/or inv	occurred at estigation, in	the time, my opin	date and	place, a occurre	and due to the ca	ause(s) and ate and pla	d manner as s ce, and due t	stated. o the cause(s	)
	To the To the Comp	×	29b. Signature and title of certifier	ν 1			29c. L	icense n	number		2	9d. Date si	gned (Month,	Day, Year)	
	a.			IV( 3	)	1	-	1)	231	5 2		.5	19	104	
	80		30. Name and address of person w	no completed cause o	Kerulu	23a) (Type, F	Print) Ahe.	K	Piver.	ilele	md.	20	137		
Spir.	Sta Registr		31. Date filed (Month, Day, Year)	2/	strar's Signatu	ire					7.				
	negistr	at	FEB 11	2004	Cara A	7. A	BARL								

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmer e <i>rtificat</i>	it of He	alth and <i>eath</i>		jiene 2 leg. No.	2004	04027
	Physici		1. Decedent's Name (First, Middle, Last		12				2. Date of Dea	th Day	Year	3. Time of Death
10 mg	/Medio Examin		4a. Facility Name (If not institution, give 218 E. Barney St	street and number)		4b. City,		ocation of Dea	ith	1	unty of Death	,
	Funeral Director		5. Social Security Number 217–16–4303 6. Se	7. Age	(In yrs. last birthday 82 Yrs.	/) If Under Months		If Under 24 Hr Hours Mir		, Year)	Cour	place (State or Foreign htry)
	Maryland	tor	10a. State 10b. County	I/A	10c. City, Town or I	ocation	I	Baltimo	re City		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a	ai Director	10e. Street and Number 218 E. Barney	St.		10f. Ziş	Code	212		l0g. Citizen	of What Cour USA	
3036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evacinal must be notified at	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 277N If Yes, Give Year or Dates:		. Was Dece If Yes, spe 1 Yes	cify Cuban,	panic Origin? ( Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, ecify: Wh	
Baltimore, Maryland 21215-0036	fited within 72 h Hygiene. Sther than "natu ent, Ine Medica	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+) (Giv	edent's Usu e kind of wo DO NOT u Omemak	rk done du se retired) Cer	ring most of we			of Business/Ind	dustry Home
yland	2 should be fitted and Mental Hylls marked oth	To Be	17. Father's Name (First, Middle, Last) Harry E. Suit					Marie	V. Geisl	.er		
e, Mar	1 and 2 sh Health and Iem 27 Is m		19a. Informant's Name/Relationship (7) Sandra L. Harshma 20a. Method of Disposition		218 20b. Place of Disp	B E. E	Barney		Rural Route Number t, Baltin  Date	ore M		0
Itimor	t. Page tment o rtant: If ijury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☒ Other (Specify)  21. Signature of Funeral Service Licens	<b>Emtanlament</b>	Loudon Par	matory or o	other place) tery ad Address	of Facility	y 12, 2004	Bal:	timore M	
Ba	Departing Important Import		23a. Part1. Enter the disease, or compl	icansas that caused	the death. Do not en	harles 501 Fa	L. Sta st Ford	evens Fur L Avenue	neral Home, Baltimore	MD 212	230	Approximate
68760,	Physician / Medical Examiner physicien and physicien and physicien and strength of the physician	edical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	consequence of):	Cerch	teric	lent	- Disee	×	,	Interval Between Onset and Death
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetat death 3	□Ectopic pi □ Other (sp				23d.	. Date of delive Month	ory Day Year
rds, P	w requires that been signed t should be deta	þ	Part ti. Other significent conditions con	ntributing to death bu	t not resulting in the	underlying c	ause given	in Part t.		bacco use d es 2□N		ne cause of death?
Division of Vital Records,		Completed							24a. Was a autops perform	n 24 sy ned?• 2 <b>X</b> No	4b. Were autor prior to con death? 1 \( \text{Yes} \)	psy findings available appletion of cause of
ξ	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	lospitat:	nt 2 ER/Outpatie	ent 3□ DC	0.4		ath (Check only on		1011 /0 1/	
ion of	nding Phy tth. :: After this e funeral d	ation; To	27. Manger of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injun (Month, Day			8c. Injury a Work?	4 Li Huising	Home 5 Reside			9
Divis	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Inju building, etc.	ry - At home, farm, s . <i>(Specify)</i>	treet, factory	, office		28f. Location (St City or Town		umber or Rurai	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Exami	sicien: To the best o ner: On the basis of and manner stat	examination and/or ii	nvestigation	, in my opin	ion, death occ	urred at the time, d	ate and pla	ce, and due to	the cause(s)
	To Troo	2	29b. Signalus, and title of certifier	of trust		290	License n	number Nelel	5	9d. Date si	gned (Month, L	Day, Year)
	フ		30. Name and address of person who co	A 10-6	101 E-	, Print)	tu	l. Go	Limort	W	0) 2	1230
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 1	32. Registra	rs Signature	Lessel						

			1 - For State Registrar	State of M	larylar			ent of Hea a <i>te of De</i>		fental Hyg R	iene /	UUH	
			1. Decedent's Name (First, Middle, Las	t)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		MEBECCA	F. Ke	ARN	CY				FEB	02	2004	8:25 PM
	Examin		4a. Fecility Name (If not institution, give	street and number	)			ty, Town, or Loc				nty of Death	·
			HOWARD COON				C	DLUM!	BIA			S CO PSY	
	Funeral		5. Social Security Number 6. S	9x 7.A □M 2∑ F		last birthday) Yrs.	Month	201 1 1 002	Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign htry)
	Director		219-30-8792 1 Usual Residence of Decedent		81	TTS.				Sept 6,	1922	Nort	th Carolina
	and and		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	<u> </u>				1	0d. Inside City Limits
	Mary	ō	MD Howard		E	11icot	t Ci	Lty					1 ☐ Yes 2√ No
	28a	rec	10e. Street and Number		1		10f.	Zip Code		1	0g. Citizen o	of What Cour	ntry?
	3a or		3200 North Ridge	Road				210	043		1	USA	
	death Tan 2	Funeral Director	11. Marital Status	12. Was Deceden	Ever in U	.S. 13.	Was De			ecify Yes or No- Rican, etc.)	14. R	ace - Americ	
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "netural", or itema 23a or 28a-f ahow event, the Modical Exam, art must be notified at	by Fur	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Tyes 2 Tyes  If Yes, Give  Year or Dates:	No				pecify:	Alcan, etc.)	Spec	lack, White. <sup>cify:</sup> wh	ite
Š	2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	dent's U	sual Occupation	1		16b. Kind of	Business/Ind	dustry
212	hin 7.	Completed	(Specify only highest gra	de completea) College (1-4or	5+)	life.	DO NO	work done durin Tuse retired)	g most or work	ing			
2121	filed within Hygiene. other then ent, the My	No.	12	5			reg	istered	nurse		h	nealth	
9	al Hy loth	Be (	17. Father's Name (First, Middle, Last)					18.	Mother's Name	e (First, Middle, I	Maiden Sum	ame)	
<u>Na</u>		고 고	William Ellis	Kearney						lnora Mo			
Maryland	~ ~ = =		19a. Informant's Name/Relationship (	•		1				al Route Number			Code)
	C = 44 F		Thomas Kearney/n	ephew	005					le Balt			21228
more,	Se do L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify		1 /	Place of Dispo cemetery, crei	matory o	vame or or other place)		Jare	20c. Location	n - City or To	own, State
Balti	permit. Pages Department of Important: if It any injury or once.		21. Signature of Forter   Service Licer Ronald S.	Wade Dir	ecto	r St	tate	and Address of Anatom more, M	y Board	655 W.	Balti	more S	treet
	100		23a. Patt1. Enter the disease, or com shock, or heart failure. List only	olications that cause	d the deat						est,		Approximate Interval Between
18 17 18	Physician		Immediate Cause (Final			2CSP1F	2 ^ 7	~ Qu !	ARRES	-			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a			<u> </u>	0129	31162	. [			
M	Examiner			. Su	2515							ı	O DAYS
42		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a									
	cuted nd ransi	Examiner	that initiated events	· TNO	<u>}</u> ∪m	10m7	- 1	ins a	RINNARU	TRACT	INFO	sen '	10 DAYS
Ö,	e exe ian a urial-t	Ä	resulting in death) Last	Due to (or a	s a consec	quence of):							
58760,	icate be executed physician and s the burial-transit	edlcal		. d									
_			IF FEMALE:										
Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Feta	al death 3		pregnancy				Date of delive Vi <i>on</i> th	ory Day Year
0	at the de by the a tached f	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant : 9□Unknown	at time of c	leath 5L	_] Other	(specify)					
م	that the	F.	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	ınderiyin	g cause given in	Part I.	23e. Did tot	oacco use co	ontribute to th	ne cause of death?
ds,	signed to be det	d by	CORONARY	ARIGRY	-	2SGAS	-			1 🗆 Ye	s 2,ENo	3 ☐ Prob	ably 4 Unknown
ŏ	w require been si should t	Completed	Canada	DISAG						24a. Was a	241	Were auto	psy findings available
Š	has ye 2	ш	PARKINSONS	21200	· <u>.</u>					autops	У	prior to cor death?	mpletion of cause of
a	ician; Th certificate rector, pag		- W			·				1	2 No	1 🗆 Yes	2□ No
<u> </u>	ysician; The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?	Hospital:		15000		Other		h (Check only on	1	When (0 ')	1
o	Phys	<b> -</b>	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of In	urv	ER/Outpatier		DOA		me 5 Reside			Y)
Ö	ding f th. After funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No				
Division of Vital Records,	il or Attending Physician; after death. Director; After this certifica in by the funeral director. I	Certification;	3 Suicide 6 Could not b	∠oe. Flace of f	njury - At h etc. <i>(Speci</i>	iome, farm, str fy)	reet, fac	tory, office		28f. Location (St City or Town		mber or Rura	l Route Number,
	To the Hospital of within 24 hours after the Funeral Discompletely filled in	ledical Ce		ysician: To the bes									
	the Prin 24 the F	ledi	one)	and manner s	tated.								
ı.	To To	Σ	29b. Signature and title of certifier					29c. License nu				ned (Month,	
•	1		Strem		m			2426	80		+GB	03.	2004
	M		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type,	Print)	lw-	0	4. 1. 1	Elle		2004 21042 4 mg
			SABA SITCHEN M		rario Sina	rura atura	CI	4TOWA	LVIKE	#40	اللات	שוו עו	y rng
	Sta	ite	31. Date liled (Month, Day, Year)	3 negis	trar's Sign	2010	10						

			1 - For State Registrar	of Maryland / De	partment <i>ertificate</i>			nd M	, -	jiene eg. No.	2004		29
	Physici		1. Decedent's Name (First, Middle, Last) ELIZABETH LEE LIBBY	Υ					2. Date of Dear Month February		004 Year	3. Time of D 5:00AM	eath M
	/Medic Examin		4a. Facility Name (If not institution, give street and Pickersgill	number)	4b. City, ToW:		Location of	Death			County of Death Baltin		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 A X X	7. Age (In yrs. last birthd	Months	Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day OCTODEN 2	7,191	9. Birth Coj Mary I	pplace (State or I intry) and	Foreign
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	10c. City, Town o	r Location							10d. Inside City 1 ☐ Yes 2	
	with the last or 28a-	Direct	10e. Street and Number 615 Chestnut Avenue	1003011	10f. Zip 0	2120	 И		1	0g. Citia	zen of What Cou	untry?	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show supy injury or other traumatic event, it a Madical Examinal moral be notified at once.	by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	s 200 No	13. Was Decede If Yes, specif	ent of His fy Cubar		in? (Spe Puerto I	ocify Yes or No- Rican, etc.)		4. Race - Amer Black, White		
Maryland 21215-0036	vithin 72 hound.	Completed		ed) (G	ecedent's Usual Bive kind of work fe. DO NOT use	done di retired)	tion uring most	of worki	ng		nd of Business/I	ndustry	
and 21	d be filed w ental Hygier ked other ti c event, tr	To Be Co	17. Father's Name (First, Middle, Last) Charles Murrell Williams	ā	Homemal				(First, Middle, Louise Em	Maiden .			
Maryl	d 2 shoul th and Me t7 is mark traumati	ř	19a. Informant's Name/Relationship (Type, Print) Charles L. Libby		lailing Address (							ip Code)	
a)	Pages 1 and nent of Health ant: If item 27 ury or other to		20a. Method of Disposition  XXI Burial 2 Cremation 3 Removal fro  4/\toDonation 5 Other (Specify)	om State Druid Rid			"   2	2/13/0			cation - City or T esville,		
Balti	permit. Page Department Important: If any injury or		27 Ignature of Funeral Service Licensee	Enakir	22. Name and	Address			chell-Wie Road Balt			. Home Inc nd 21212	
F	Pnysician /Medical		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death)  Due	on each line.	enter the mode d De			-	r respiratory arr	est,		Approximate Interval Betwee Onset and De	
1760,	rate be executed by the burial-transit of	Ical Examiner	cause. Differ Underlying Cause (Disease or injury that initiated events  c.	to (or as a consequence of)		·							
P.O. Box 68	death certific e attending p ed for use as	by Physician/Medi	230. Was decedent pregnant 1 Lin in the past 12 months? 4 Pr	outcome of pregnancy ve birth 2 ☐ Fetal death regnant at time of death nknown	3 □Ectopic pre 5 □ Other (spe					2	3d. Date of deli	very Day Ye	ar
Ś	puires that t n signed by ald be deta	d by Ph	Part II. Other significant conditions contributing to	a death but not resulting in the	ne underlying ca	use give	n in Part I.		23e. Did to		se contribute to	the cause of dea	
Vital Record	The law requires that the ate has been signed by th page 2 should be detache	Completed							24a. Was a autops perfor	sy	24b. Were autoprior to death?	topsy findings av ompletion of cau	vailable use of
Vita	Phyaician: The la r this certificate has ral director, page 2	To Be (	25. Was case referred to medical examiner?  1  Yes	☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA	A Othe	e Vanish		n (Check only or me 5 ☐ Resid		G ☐Other (Spec	ify)	
ion of	Attending Phir death. ector: After thiby the funeral	ation: 1	1 Natural 5 Pending (A 2 Accident investigation	ate of Injury 28b. Tim Month, Day Year) Inju	ne of 28	Bc. Injury Work 1 🗆 Y	at ? ′es 2 □ N		28d. Describe h	ow injury	occurred /		
Division	al or Atte s after de al Directo ed in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 28e. Pi determined bi	lace of Injury - At home, farm uilding, etc. <i>(Specify)</i>	i, street, factory,	office			28f. Location (S City or Tow			ral Route Numbe	9 <i>r</i> .
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical		the best of my knowledge, one basis of examination and/onanner stated.	or investigation,	in my op	inion, deat	f place, a	ed at the time, o	late and	place, and due	to the cause(s)	
	_	Σ	29b. Signature and into of certifier	Ailen n			number 500	5			e signed (Month		) /-
	10		30. Name and iddress of person who completed to		701 N	1. C	hor	les .	St. Ba	40	Md	2120/	
	Sta Regist		31. Date filed (Month, Day, Year) / 3. FEB 1 1 2004	2. Registrar's Signature	4	1.1							

ORIGINAL

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death  Reg. No. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	30
	sician		
	edical miner		111
		Continuum Care Sykesville Carroll  5. Sociel Security Number 6. Sex 7. Age (In vrs. lest birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth 9. Birthday   9.	
Fune Direct		5. Sociel Security Number  216-30-8005  7. Age (In yrs. lest birthday)  Yrs.  7. Age (In yrs. lest birthday)  Yrs.  7. Age (In yrs. lest birthday)  Yrs.  1 Under 1 Year If Under 24 Hrs.  Months Deys Hours Min.  1 Under 1 Year If Under 24 Hrs.  July Year 1934  9. Birthplace (State or F. Months)  Support Year 1934  9. Birthplace (State or F. Months)  Support Year 1934  9. Birthplace (State or F. Months)  1 Usual Residence of Decedent	Foreign
yland		10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City	Limits
the Marylar 28a-f show	ector	MD Carroll Finksburg 1 Yes 2	₽No
ath with the 23st or 2	Funeral Director	10e. Street end Number 4600 Sykesville Road #115 10f. Zip Code USA USA	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or theme 23a or 28s-1 show mit, the Medical Exercities must be notified at	by Fune	11. Maritel Status  1	
Maryland 21215-0036 nd 2 should be filed within 72 hours aff the and Mantal Hygiena. The arrived other than "natural", or traumatic event, the Medical Evant.	Be Completed by	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)  Carpenter  Construction	
nd n	BeC	17. Father's Neme (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
Maryland 212 d2 should be filed within and Mental Hygiene. The marked outper than treumstic event, the treumstic event the treumstic event.	P	John William Langrehr Mary Alberta Manner	
	ĺ	19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)  Mrs. Marie Elise Langrehr (Wife) 4600 Sykesville Rd #115 Finksburg, MD 21048	
		20a. Method of Disposition  1 Burial 2 Foremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  All County Cremation Srv 2/13/04 Sykesville, MD	
Baltimol permit. Pages Department of Important: If it	DUC	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400	
		23a. Pert1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.  Approximate Interval	en
Physicia /Medic Examin	al	Immediate Ceuse (Final disease or condition resulting in death)  a. He jantic Encejon() athy	ath
ted Asit	nlner	Due to (or es e consequence of):	
68760, tificata be executed up physician and as the burial-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or es e consequence of):  Due to (or as e consequence of):	
9 ≅ gs		that initieled events resulting in death) Lest  Due to (or as e consequence of):	
Box eath cert attending	clan		
P.O. nat tha d d by the datached	hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	_
S, F es tha igned be dail	by P	TO CONTRACTOR SEPTOBLY 4 DAIL	KIIOWII
Division of Vital Records, I or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be of	Completed by Physician/N	Recent whinay that angletin 24a. Wes an autopsy performed?  24b. Were autopsy find available prior to completion of caus of deeth?	
al R	20	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	.
Vit siclan certifi irecto	To Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospitel: 1   Inpatient 2   ER/Outpetient 3   DOA   Other: 4   Ususing Home 5   Residence 6   Other (Specific)	
On of	ion: T	27. Menner of Death 1 Matural 5 Pending 28e. Date of Injury 28b. Time of Injury Work? 28d. Describe how injury occurred Work?	
or Attendation of Att	ertificat	2 Accident investigation 3 Suicide 4 Homicide investigation 3 Suicide 4 Homicide investigation 3 Suicide 4 Homicide investigation 5 Suicide 4 Homicide investigation 5 Suicide 6 Could not be determined investigation 5 Suicide 6 Could not be determined investigation 6 Suicide 6	;
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeria Director: After this certificate has been signed by the attending completally filled in by the funeral director, page 2 should be datached for use.	edical Certification:	29a. Certifier (Check anly one)  1. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner steted.	
To the To the Comp	Ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	
		30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)  SHAHDA SIDDIOT 6212 SY KESVILLE ROAD 21784	
Regi	state strar	31. Dete filed (Month, Dey, Year)  32. Registrar's Signeture	
DHMH 16 Rev	5/95	ORIGINAL	

			1 - For State o	f Maryland / De <i>C</i>	partment of H ertificate of I			iene	4 04031
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physici		ALFONZO		MCK	COV	Month FEB.	08 20	1004 11:20PM
	/Medic Examir		4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, or	Location of Death		4c. County of	Death
			JOSEPH RITCHIE	HOSPICE	BI	9LTIMO	RE		NIA
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	Birthplace (State or Foreign Country)
	Director		219-76-4869 12M 20F	44 Yrs			FEB. 18	,1959	MARYLAND
	pur A		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	with the Maryland e or 28a-f show	៦	MARILAND NA		BAI	T: 110	o- M.	71/	12 Yes 2 □ No
	28a-1	ect	10e. Street and Number		10f. Zip Code	TI HOF		Og. Citizen of Wh	nat Country?
	with	ā	1520 ARGULE	AVENUE	701. Elp 3000	-2/2/	7	//.	5 1
3	death w	Funeral Director	11 Marital Status 12. Was Dec		3. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-		- American Indian,
000	rher	F	1 Never Married 2 Married 1 ☐ Yes	rces? 2 XNo	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>		Rican, etc.)	Black,	, White, etc.
3	ius after death with the Maryla af, or Items 23e or 28a-f shoi Exemirer must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Gir Year or D	ve ates:	1 ☐ Yes 2 ☑ No	Specify:		Specify:	BLACK
20	72 hours "naturel", colcet Exe	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occup-	ation	ina	16b. Kind of Busi	iness/Industry
21:	within i	nple	Elementary/Secondary (0-12) College (	life	e. DO NOT use retired	1)	,	4.1	
(3) 24	filed wither the	ပ်	9 THGRADE		LAB	OREK			IMPROVEMENT
o br	tai H d oth	Be	17. Father's Name (First, Middle, Last)	. /		18. Mother's Name	e (First, Middle, I		
<u> a</u>	ouid Men Marke	၉	ALFONZO MCKO				THA		DALKER
$\psi \left( \begin{array}{c} \downarrow \\ Maryland \end{array} \right)$	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other treumatic event, the Magnee.		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street		90 0000		
0 0	fealth fealth am 2 ther t		THELMA MINOR (STEX 20a. Method of Disposition	20h. Place of Di	Sposition (Name of	YLEAV	Date Date	ACTION OF	E 140 2/2/7
	ges if of the	-	1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from	State cemetery, o	crematory or other plac	ce)			
8   C	t. Pa tmen tant: sjury		'4 □Donation 5 □Other (Specify)	METRO	CREMATO	RY 1002-1	1-04		YORE MARYLAW
≥ ABal	permi Deper impo any ir		21. Signature of Euneral Service Licensee	Diamo	22. Name and Address	SS Facility	3ROW1		EUNERAL HOME
	40.240		222 Part Fater the disease or complications that	ceessor Do and	2140 h	1. 1-42 TO	NAVE.	DALT	0, MD, 2/2/1 Approximate
			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on a	each line.	enter the mode or dyin	ig, such as cardiac o	or respiratory arm	est,	fnterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	nsmall ce	ll lung C	accinom	in		5 yrs
	/Medical Examiner		Due to	(or as a consequence of):	1				
		-	Sequentially list conditions b.	(or as a consequence of):					
	led Isit	- P	So uential y list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	(or as a consequence or).					
₹.	xecur and	Examiner	that inflated events c.	(or as a consequence of):					
	ate be executed hysicien and the burial-transit	cal E							
289	tificate ng phys as the		0.				-n		
Q X	eath certifica attending pt for use as t	Physician/Med	IF FEMALE: 23c. If yes, ou	tcome of pregnancy				23d. Date	of delivery
	that the death cer ed by the attendir detached for use	Cla	in the past 12 months?	nant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	<u>′</u>		Mont	-
0,0	it the di by the tached	hys	9 Unknown 9 Unkn	own					
S. F.	The law requires that the te has been signed by the age 2 should be detache	by P	Part II. Other significant conditions contributing to d	eath but not resulting in th	e underlying cause giv	en in Part I.	23e. Did tol	bacco use contrib	oute to the cause of death?
	w requires been sign should be						1 □ Ye	es 2□No 3	G Tobably 4 ☐Unknown
ುರಿ ಗಿ S ೆ Vital Record	aw requ is been 2 should	Completed					24a. Was a	n 24b. W	ere autopsy findings available
S &	The lav	E					autops perfori 1 Yes	ned? de	ior to completion of cause of eath? □ Yes 2 2 No
Z I	W CT	0	25. Was case referred to medical			26. Place of Deatl			1
p ho n	Physician: this certific ral director,	ToB	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpa	tient 3 DOA Oth	er: 4 Nursing Ho	me 5 Reside	ence 6 Other	(Specify) + CSDICE
h of		i.	27. Manner of Death 28a. Date (Mon	of Injury 28b. Tim		y at	28d. Describe ho	ow injury occurred	d
_ io	Attending r death. sctor: After oy the fune	atic	2 Accident investigation		M 1 🗆	Yes 2 □ No			
Division	or Attender deat	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of tnjury - At home, farm, ing, etc. (Specify)	street, factory, office		28f. Location (Si City or Town		r or Rural Route Number,
۵	itaf o irs aft rai Di ted ir							ALPEUL TOT	
P	To the Hospital or Attent within 24 hours after death 170 the Funeral Director: c, mpletely filled in by the	Medical	29a. Certifier (Check only 2 Medical Examiner: On the bone)	e best of my knowledge, deasis of examination and/or liner stated.	eath occurred at the tin r investigation, in my o	me, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and man ate and place, an	ner as stated. nd due to the cause(s)
	To the To the	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)
	, , ,	1	> STS MD		12	4170	•	Februar	49.2004
	N		30. Name and address of person of completed cau	se of death (Item 23a) (Ty	pe, Print)	- 1		- >1 1000	1 17 1
_	•	1	E. Tso MD Richey	Hospice .	138 N. E	entan St	134	Himor	MD 21201
	St Regist	ate		Registrar's Signature	9 40 -				
	negist	ावा	TED 1 1 200/ /08	Com Mi A	WAST!				

ORIGINAL

RKD

			1 - For Unpended Item#23:	State of Mar a,27,28a-f,Per	yland / Depa ME,G828	artment of H	lealth and Death	Mental Hy	giene 2004	04032			
			Decedent's Name (First, Middle, La.		-			2. Date of Dea	ath	3. Time of Death			
	Physici /Medio		MICHAEL	JUAN	MONT	GOMER	ZV	FEBRUAR	Y 7,2004 Year	7:11P. M			
	Examin		4a. Facility Name (If not institution, given BON SECOUR HOSPIT	4c. County of Deat	) /A								
<i>₩</i>	Funeral Director		5. Social Security Number 6. S  218-74-5590  1  Usual Residence of Decedent	ex 7. Age (	8. Date of Birt (Month, Da	h, Year) 9. Birt Co 23: 1959 M	hplace (State or Foreign untry)						
	laryland ahow		10a. State 10b. County	1	Oc. City, Town or Lo	cation			,	10d. Inside City Limits			
	Mary Ind	tor	MARILLAND 1	)/A		BAITI	HORF	CITY	1	1 □ Yes 2 □ No			
	or 28g	Director	10e. Street and Number			10f. Zip Code		7	10g. Citizen of What Co	untry?			
	ath wi	ral	3115. M	ASON C	OURT	<	2123	1	010	A.			
	items	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (: n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White				
920	be filed within 72 hours after death with the Maryland tal Hygiene.  dother than "natural", or items 23e or 28e-f ahow event. The Modical Examining to indifficial at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2⊠No	Specity:		Specify:	JACK			
21215-0036	72 ho	Completed	15. Decedent's Ec		(Give	dent's Usual Occupa	during most of we	orkina	16b. Kind of Business/	Industry			
121	within one. Ihan	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired			. 1/				
	filed with Hygiene. other than	e Co	9+If GRADE  17. Father's Name (First, Middle, Last)		I UNE	=MPLO		me (First, Middle,	Maiden Sumame)	<u>t</u>			
Maryland	should be filed within not Mental Hygiene. marked other than imatic event, the M	To B	ALBERT J	AMES	MONTGO	MERY	MARI	GARFT	VIRGINIA	BELL			
ary	2 should and Men la marke aumatic		19a. Informant's Name/Relationship (						or, City or Town, State, Z	(ip Code)			
	7.2 ad		MARGARET RICE	MOTHE			450N(	T. BA	LTIMORE, M	10.21231			
õ	90 = 5		20a. Method of Disposition  1. Burial 2 ☐ Cremation 3 ☐		,	natory or other place	· 1	Date/	20c. Location - City or				
Baltimore,			*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		MT. ZIO	N CEMET.  2. Name and Address	ERY 02-1	13-04	LANSDOWN	EMARYLAND			
Ba	permit. Departn Importa any inju		Lutich 1	V. u dela	ans =	J9851	HHX	ON AVE	JR, FUN	MA 21217			
			23a. Part1. Enter the disease, or com shock, or heart lailure. List only	plications that caused the	e death. Do not ent	er the mode of dying	g, such as cardia			Approximate Interval Between			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	Naroutic	Intoxicatio	n				Onset and Death			
			resulting in death)	Due to (or as a	consequence of):								
		er	Sequentially list conditions,	b. Due to for as a c									
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
0,	an an an irial-tra		resulting in death) Last		consequence of):								
8760	ate be executed thysician and the burial-transit	dical		d									
9 xo	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of	Dregnancy				004 Day 4 445				
Bo	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir			Month	23d. Date of delivery Month Day Year					
P.O.	at the de by the a tached	Physician/Me	9 Unknown	9□ Unknown									
Ś	quires tha en signed l ould be del	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute to es 2 dixo 3 □ Pro	the cause of death?  obably 4 Dunknown			
Record	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be delached for use as the burial-transit	Completed						24a. Was a autop perfor	sy prior to g	topsy findings available completion of cause of			
Vital	cien: Th ertificate ector, pag	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or					
of \	Physicien: this certific rat director.	2	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 R/Outpatier		4   Nursing i		ence 6 Other (Spec	city)			
	ing Affer une	tion	27. Manner of Death  1 Natural 5 Pending investigation	For Month, Day Y	ltaina'	Work	rat (? Yes 2 <b>\Q</b> \No	unknown	ow injury occurred				
Division	al or Attending after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☑ Could not be	2/ // 04	- At home, larm, str (Specify)	Ζρ		281. Location (S	treet and Number or Ru	ral Route Number,			
Ö	i i c	Certification:	4  Homicide determined	2000 Ridg	ehill Avenue,I	Baltimore,MD							
	To the Hospital within 24 hours at To the Funeral D completely filled it	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of a niner: On the basis of ea and manner state	kamination and/or in	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the durred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)			
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	N o le		29c. License	number	2	29d. Date signed (Month	i, Day, Year)			
}			Mounte !	melshill	J MP	O.C.	.M.E.	F	EBRUARY 8,2	004			
			30. Name and address of person who	completed cause of dea			Stroot	Raltimor	e, Maryland	21201			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature		outeet,	TOT LIKE	C) LEGILY LOUID				
	Registr		FEB 1 1 2004	Gene	19 1	parks.							

		1	For State Registrar	State of M		d / Depa		of He	ealth a				•	04033	
			Decedent's Name (First, Middle, L.	ast)							2. Date of Deat			3. Time of Death	
	sicia		John William M	cCleary							Month Februar	Day	, 2004	4:45 PM	
	edica mine		4a. Facility Name (If not institution, ga		r)		4b. City, To	own, or L	ocation of	f Death	I COLUCI	*	County of Deal		
LAG	mme		1239 South Phi					erde					Harfo	ord	
Fune	ral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. Ia	ast birthday)	If Under 1	Year	If Under 2		8. Date of Birth (Month, Day,	<u> </u>		hplace (State or Foreign	
Direc		-	262-13-3836 Usual Residence of Decedent	<b>X</b> XM 2□ F	49	Yrs.	Months [	Days	Hours	Min.	Aug. 12	2, 19	954 Mar	ryland	
land ow		-	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	
death with the Maryland		ğ	Maryland Har	ford	Δ.	berdee	'n							1 ☐ Yes 2 XNo	
1 the		Director	10e. Street and Number	IOIU		DCLACE	10f. Zip Co	ode			1:	0g. Citiz	en of What Co	ountry?	
3a o			1239 South Phil	adelphia E	Blvd.		21	1001					USA		
death		Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S								14. Race - American Indian,		
affer of		Ī	1 ☐ Never Married 2 ☑ Married	Armed Forces						, Puerto I	Rican, etc.)		Black, White, etc.		
Sur		þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:						Specify:			3	Specify:	White	
d ZIZIO-0000 filed within 72 hours after Hygiene.		Completed	15. Decedent's i (Specify only highest g				lent's Usual (			of worki	20	16b. Kin	d of Business	Industry	
thin thin		ᇍ	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	OO NOT use	retired)			.9				
A dien		Ö		2			Disa								
d be file		Be	by 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden St									· ·			
should be ind Mental branked o		္	Clarence Edward	McCleary	?				Lau	iren:	la Edmi	ind I	Rimback	<u> </u>	
Shirt and and send			19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (S	Street ar	nd Number	r or Rura	l Route Number	City or	Town, State, 2	Zip Code)	
1 and 1 Health			Cindy K. McCle	ary / Wife					ilade				Carried Statement	, MD 21001	
of He			20a. Method of Disposition  1 Darrial 2/2 Cremation 3	— □Removal from State		ace of Dispo emetery, cren	sition (Name natory or othe	of er place,	)		ate	20c. Loc	ation - City or	Town, State	
permit. Pages Department of Important: If it			4 Domation 5 Other (Spec	ify)	Hi.	11top	Servic	ce Co	orp.2	2-16-	-04 T	owso	on, Mar	yland	
Dall permit. Departi Import	once.		21. Signature of Furteral Service Lic	ensee		22 M	. Name and A	Address	of Facility	Hon	æ, P.A.				
D 80 E	id		Man and	21/		1	317 Cc	kes	bury	Road	l, Abing	don,	Maryl	and 21009	
			23a. Part . Enter the disease, or co	mplications that cause y one cause on each	ed the death line.	. Do not ent	er the mode o	of dying,	, such as o	cardiac o	r respiratory arre	est,		Approximate Interval Between	
Physici	an		Immediate Cause (Final disease or condition	131	eval	FI	Gice.							Onset and Death	
/Medio	al		resulting in death)	a	s a consequ	ence of):	1 0(25)	DA						or wick?	
Examir	er	1	Convention has list accorditions	b. Seps	515										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):													
cuter		am	Cause (Disease or injury that initiated events	. USt	eo n	1/21	THS								
COIGS, P.O. BOX 68/60, wrequires that the death certificate be executed been signed by the attending physician and should be deapped for use as the burial tracet		Ĕ	resulting in death) Last	Due to (or a	s a consequ	ience of):	7								
ate be e		ica		d											
ortifical		Physician/Med	IF FEMALE:												
ath ce		an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth			Ectopic preg	nancy				23	3d. Date of del	,	
he death the attent		SIC	1 Yes 2 No	4☐Pregnant 9☐Unknown	at time of de	eath 5	Other (spec	:ify)					Month	Day Year	
at the d by th		٩ ک									00 01111				
OrdS, Prequires that seen signed be dead		۵	Part II. Other significant conditions	contributing to death	but not resu	liting in the ui	nderlying cau	ise giver	n in Part I.			7		the cause of death?	
HECOTOS he law requires e has been sign		ompleted									1 🗆 Ye	es 2,42	No 3□Pr	obabiy 4 Unknown	
law law las b		ble									24a. Was a autops		24b. Were at	utopsy findings available completion of cause of	
_ ⊢ ± 2	A	Con									perform	ńęd? 2D No	death?	2 □ No	
OT VITAL HEC Physician: The law rthis certificate has be		Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on	Θ)			
Physic this of		ို	1 ☐ Yes 2 No	Hospital: 1 Inpar	tient 2 1	ER/Outpatien	t 3 DOA	Other	. 4 ☐ Nur	rsing Hor	ne 5 A eside	nce 6	□Other (Spe	cify)	
ng P.		ü.	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	280	Work?		2	28d. Describe ho	w injury	occurred		
VISION Attending r death. ector: After		cat	2 ☐ Accident investigate				М	1 🗆 Y	es 2□N	40					
JIVISION or Attending after death. Director: Afte		Certification;	3 Suicide 6 Could not determine	d 200. Place of I	njury - At ho etc. <i>(Specil</i> y	me, farm, str	eet, factory, o	office		1	28f. Location (St City or Town		Number or A	ural Route Number,	
pltal of urs all peral D			20-0-45	L. T. M. L.				Marie III			22, 22, 22	11.72.27	VIII		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific mondards tilted in human director.	9191	edical	29a. Certifier (Check only one)  Certifying I	Physician: To the bes aminer: On the basis and manner:	of examinat	ion and/or in	occurred at vestigation, in	the time n my opi	nion, deat	n place, a	and due to the ca ed at the time, d	ause(s) a ate and p	and manner as place, and due	s stated. to the cause(s)	
To the To the		Me	29b. Signature and the of certifier		>	/	29c. l	License	number		2	9d. Date	signed (Mont	h, Day, Year)	
	11		> > YWA	MA WV	own	W		1+	1106	9	IF	ehr	rudvu	10,2004	
20			30. Name and or ress of person wh	o compleed cause of	death (Item	23a) (Type,	Print)	1	. 1	+		10	ruavy	1 4. 4	
			DR. STANLEY	LMW 13	08 3	social	s Cen	ter	Wai	4 5	e 102	Eo	Agewa	20 70	
T I	Stat		31. Date filed (Month, Day, Year)	32. Regis	trar's Signat		0.11			(					
Rec	gistra	ir	CCD 1 1 2004	( dans	fred	BO	M. R. S.								

			1 - For State of Mary	land / Depa		Health and North	Mental Hygie		04034			
	Physicia /Medic		Decedent's Name (First, Middle, Last)     Thomas Edward Munnal				2. Date of Death Month Fe by war		3. Time of Death 20:44P. M			
	Examin Funeral	er		yrs. last birthday)	Balt If Under 1 Ye			N/A  9. Birth				
	Director	or.	Usual Residence of Decedent  10a. State 10b. County 10c	39 Yrs. c. City, Town or Lo Baltimore		ys Hours Min.	April 2		place (State or Foreign intry) nnsylvania  10d. Inside City Limits 1 □ Yes 2 🛣 No			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner moral by multiped at once.	Completed by Funeral Director	10e. Street and Number 206 Haile Ave.		10f. Zip Code 21225	j	τ	. Citizen of What Cou	intry?			
9600	hours after de ural', or items Examiner o	d by Fune	11. Marital Status  MXNever Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever Armed Forces?  1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C  1 ☐ Yes 2 ▼ N  dent's Usual Occ				hite			
Baltimore, Maryland 21215-0036	ted within 72 l lygiene. her than "nat it, the Medic	Complete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)	b. Kind of Business/Ir	ndustry							
larylanc	2 should be fi and Mental H le marked ot aumatic ever	To Be	Norman Ray Munnal, Sr.  19a. Informant's Name/Relationship (Type, Print)		-	Phyllis		d ity or Town, State, Zi				
more, N	Pages 1 and nent of Health ont: If Item 27 ury or other tr		Beverly Hamilton, sister  20a. Method of Disposition 1 Bunal 2 Ocremation 3 Removal from State 4 Donation 5 Other (Specify)	4008  b. Place of Dispo  a cometory creations  a yview	sition (Name of	n/ann)	Date 20	timore, MI c. Location - City or T altimore,	own, State			
Balti	Departition Departition Departition Departition Departition Departition Department Depar		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caused the	1	.328_Su1	dress of Facility Funeral Ho phur Sprin tying, such as cardiac	g Rd. Ar		21227 Approximate Interval Between			
•	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  List only one cause on each line.  Care how va Schlier  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
8766	cate be executed obly sician and the burial-transit	Ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a condition of the c									
ර P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of properties of the past 12 morths? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnal			23d. Date of deliv Month	ery Day Year			
Records, P	w requires that been signed should be det	ted by P	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1   Yes 2   No 3									
a	in: The law ificate has b or, page 2 sl	e Completed	25. Was case referred to medical			OC Place of Deat	24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of			
on of Vit	To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	examiner?	2 ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 Nursing Ho	th (Check only one) ime 5 ☐ Residence 28d. Describe how	e 6 Other (Special	(y)			
M CAN N Division	pital or Attendi	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - building, etc. (S)	pecify)	eet, factory, offic	ce	City or Town, S					
	To the Hospital or within 24 hours effe to the Funeral Dit completely filled in	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my 2 ☐ Medical Exeminer: On the basis of examiner and manner stated.  29b. Signature and title of certifier	mination and/or inv	estigation, in m	y opinion, death occur	red at the time, date	and place, and due t  Date signed (Month,	Day, Year)			
	i		1) 38543 February 5, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (EVEN 14. Scrubas and God Catm Avanue Bultmore Manylund									
	Sta Registr		REVEN 14. SCRUGAS AU 31. Date filed (Month, Day, Year) 32. Registrar's S EED 1 1 2004	-	4	or plant	ix plus	irrust iv	any insul			

			1 - For State Registrer	State of M	Marylan	id / Depa <i>Cei</i>	artment o	f Health of Death	and M	lental Hyg	iene	04	04035		
	Physic /Medi Exami	cal		clity Name (If not institution, give street and number)					of Death	2. Date of Deat Month Feb	Day	Year Co 4 of Death	3. Time of Death  5:18 AM		
Funera Directo					ente Age (In yrs. 75	last birthday) Yrs.	If Under 1 Ye Months Da	timer ear If Under eys Hours	-	8. Date of Birth (Month, Day, April 2	N/A Year) 26, 192	9. Birthpla Country 8 Mar	ce (State or Foreign Y) Cyland		
Ind 21215-0036 be filed within 72 hours after death with the Maryland lata Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Exercities must be notified at	he Maryland Ba-f show	ector	Maryland Baltim	ore	10c. City Balt	y, Town or Lo	cation Highlan	nds				100	d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	death with the ms 23a or 2	eral Dire	10e. Street and Number 3813 Annapolis	12. Was Deceder	10f. Zip Cod	27	igin? (Spe	0g. Citizen of What Country?  U. S. A.  14. Race - American Indian.							
-0036	hours after tural; or ite	ed by Fur	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces  1	;? }No	1	☐Yes 2🔯	No Specify:		ecify Yes or No- Rican, etc.)	Specify.	k, White, etc Wh	ite		
Maryland 2	filed within 72 Hygiene. other than "na ent, It e Medic	Completed by Funeral Director	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)		ent's Usual Oc kind of work do OO NOT use re Manage		t of workii	-	Grocery				
	d 2 should be fil th and Mental H ?7 is marked oit traumatic even	To Be	17. Father's Name (First, Middle, La Henry Martin Mil 19a Informant's Name/Relationship	ler		19b. Mailin	a Address (Stre	E1e	anor	(First, Middle, MANNA Ro	eder	,	ada l		
	1 and 2 Health a em 27 Is		Alan E. Cramblit	t, nephew	20b. Pl	3813 ace of Dispos	Annapo Sition (Name of Satory or other p	olis Rd	• Ba	altimore	Highla Oc. Location - 0	nds,	MD. 2122		
Baltimore,	permit. Pages Department of Importent: if it any njury or o		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice	cify)	New	22 A	dral Ce Name and Add mbrose	dress of Facilit Funera	Hom	ne, Inc.	Baltimo		)		
	icate be executed  Medical  Medical  Street be executed  Medical  Street be executed  Medical  Medical	ai Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Se Due to (or a:  b. Due to (or a:  Due to (or a:	s a conseque	ence of):	rthe mode of c	tying, such as	cardiac or	Rd A	st,	Ar	21227 poproximate terval Between inset and Death Days  Days  Days  Days		
.O. Box 687	Physicien: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3⊟8	Ectopic pregnar Other <i>(specify)</i>				23d. Date Mont	of delivery h Day	y Year		
ords, P.	w requires that been signed b should be deta	ted by Pł	Λ: α									s 2 No 3 Probably 4 Onknown			
Vital Records,	ilcien: The law i certificate has bi rector, page 2 sh	e Completed								24a. Was an autopsy performe	ed? de	ere autopsy or to comple ath? Yes 2	findings available ation of cause of No		
E E	After fune	To B	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death 1   Natural   5   Pending investigati	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	iry 2	P/Outpatient 28b. Time of Injury	28c. Inj	ther: 4 Nur	sing Hom	(Check only one)  e 5 Thesiden  dd. Describe how	ce 6 Other	(Specify)			
Divis	spitel or Attendous after death ours after death nerel Director: filled in by the	il Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check ont)  1 Certifying Physician: To the best of my knowledge, death occurred at the time.							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by 1	Medical	(Check only 2 Medicel Exa	miner: On the basis of and manner st	a examination	on and/or inve	stigation, in my	ropinion, death	place, an	at the time, date	se(s) and mann a and place, an . Date signed (	d due to the	cause(s)		
	6		30. Name and address of person who	2 1	leath (Item 2	23a) (Type, Pi	1	1677		+ P.	timor	, 20	704		
	Star Registra		31. Date filed (Month, Day, Year) FEB 1 1	/	ar's Signatu	re Ly	Low	the s	tree	· Da	a Imor	٠٤, ١	nD 2/225		

			For State Registrar	State of Mar	yland /	Depa	ırtmer	nt of H	ealth ar Death	nd Me	ntal Hyg	giene /	2004	040	36	
y —	Physici /Medic	al	Decedent's Name (First, Middle, Last)     Ronald     4a. Fecility Name (If not institution, give s	Paul	Мо	rin	4b. City	, Town, or	Location of	F	Date of Dea Month ebrua	ry Z	Year 200 ounty of Deeth			
	Funeral Director	CI	Frederick Memori 5. Social Security Number 6. Sex	ial Hospita	al (In yrs. last l	<i>birthd</i> ay) Yrs.	If Unde	r 1 Year	erick Hours	4 Hrs. 8 Min. (	Date of Birtl (Month, Day Oct 13	1	rederi 9 Birth Cou New	.ck place (State or Fo ntry) Hampshi	oreign re	
1215-0036 within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28a-1 ehow he Medical Examiner must be notified at	ctor	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Frederick Frederic											10d. Inside City L 1 ☐ Yes 2§			
ath with th	23a or 2	Funeral Director	6188 Viewsite Cour					2 <b>17</b> 0				U.S	Og. Citizen of What Country? U.S.A.			
036	al', or Items	þ	11. Marital Status  1 Never Married	12. Was Decedent Eventh Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1			spanic Origi n, Mexican, Specify:	in? (Specr Puerto Ri	Decify Yes or No- Decify Rican, etc.)  14. Race - American Indian Black, White, etc.  Specify: White			, etc.		
21215-0	marked other than "natural", or liems 23a or 28a-1 ehow marked other than "natural", or liems 23a or 28a-1 ehow matic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give kind of life. DO NO						ent's Usual Occupation kind of work done during most of working IO NOT use retired) tor of Operations					16b. Kind of Business/Industry  Technical Company		
Baltimore, Maryland 21215-0036	Mental Hyginarked other	To Be C	9	niel		rin		100	Bla	nche	First, Middle,	Riche				
e, Mar	the sith and the sith and the sither the sin		19a. Informant's Name/Relationship (Typ. Mrs. Sharon Morin/ 20a. Method of Disposition		1	<b>61</b> 88	Vie	wsite	Cour		rederio	ck, M	own, State, Zij aryland Ition - City or T	1 21701		
altimor	Department of Health and Mental Important: If Item 27 Is marked eny injury or other traumatic events.		1 Burial 2 X Cremation 3 Ri 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	90	Smitl	nsbur 22	g Cr	emat	ory so of Facility	- e <sub></sub> .			thsbur			
760,	hysician and //Medical kaminer parial-transit	dicai Examiner	d									ick, Ma	oproximate Interval Betwee Onset and Dea	in .th		
O. Box	ed by the attending detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year		r				
rds, P	been signed b	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of Seizures  1   Yes 2 X No 3   Probably 4 (													
	icate has been case, page 2 should	Completed	Hypoglycemia wit	h Mental S	Status	s_Cha	anges	3		_			24b. Were auto prior to co death? 1 🗌 Yes	opsy findings ava ompletion of caus 2 \( \text{No} \)	ilable e of	
of Vita	nis certifi I director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								ify)				
sion o	death. ctor: After th		27. Manner of Death  1 XNatural 5 Pending investigation	o. Time of Injury	м	28c. Injun Work 1 🗆 `	vat <br Yes 2 □ N		d. Describe h	iow injury o	occurred					
Division	within 24 hours after death.  To the Funeral Director: After this certificate ha	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	(Specify)			THE RESERVE			City or Tow	m, State)		ral Route Number,	,	
	thin 24 hours at the Funeral I	edical	(Check only one)	ner: On the basis of e and manner state	examination ed.	and/or inv	vestigatio	n, in my of	oinion, death	occurred						
)	within To the	Σ	29b. Signature and title of certifier	Hude	2000	al		D39					signed <i>(Month,</i> cuary 5			
	6		30. Name and address of person who co Karen Hundemer, N	1.D., 65-C	Thoma	as Jo		on Dr	ive, I	rede	rick,	Maryl	Land 21	702	-87	
14	Sta Registi		31. Date filed (Month, Day, Year)  FFR 1 1 2	32. Registrar	's Signature	1	4	bou	EN							

-e		1- State Amend Items 4c, 24a, 25, 26, 27 and 29a per Principle 24 hb 24 hb  1. Decedent's Name (First, Middle, Last)	2. Date of Deat	og. No. 2004 040
Physic /Medi	cal	Flora B. Mauney  4a. Facility Name (If not institution, give street and number)  4b. City. Town, or Location of Dea	Month 1	Day Year 4 2004 7:00
Examir	ner	The Garden of Grace Assisted Living Ellicott City	ith	4c. County of Death Balto
uneral irector		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Under 1 Year   If Under 24 Hr.  99 Yrs.   Months   Days   Hours   Min		Year) 9. Birthplace (State or Fo
r 28a-f show notified at	Funeral Director	10a. State		10d. Inside City ⊔ 1 ∐ Yes 2 ሺ
23a or	alD	3125 The Oaks Road 21043	10	0g. Citizen of What Country? USA
or items miner m	þ	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Specify:  1 □ Yes 2 ☒ No Specify:	Specify Yes or No- no Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
ther then "natural", out, the Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 8th grade  15a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 1	16b. Kind of Business/Industry Private Homes
	To Be C	17. Father's Name (First, Middle, Last)  John L. Brewer  Lora J	me (First, Middle, M Propet	
If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print)  Stephanie Johnson Great-Niece  2850 Bethany Lane		
ant: If ite lury or ot		1 ABurial 2 Cremation 3 Removat from State	Date 2	Oc. Location - City or Town, State Concord, N.C.
Important: I any injury o once.			arch F/H	
physician and dictal stransit and private stransit	Еха	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		st, Approximate interval Between Onset and Death
or use as		tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
pe e .	ַ הַ מ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?
page 2	e Completed	25. Was case referred to medical	24a. Was an autopsy performent   Yes 2 🔀	24b. Were autopsy findings availa prior to completion of cause of death?  No 1 Yes 2 No
10	ation: 10 B	1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Ho	th (Check only one) ome 5  Residence 28d. Describe how	- Inno
ed in by th	Certification:	3 Suicide 6 Could not be	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
npietely fill		29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
100	Σ 2	19b. Signalare and find of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	3	P. Name and address of person who completed cause of death (Item 23a) (Type, Print)	+ MD	7 2007

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of L		А	eg. No.	004	04038
H	Physici	an	1. Decedent's Name (First, Middle, Las	t)	c	MILLER		2. Date of Dea Month	Day	Yeer	3. Time of Death 9:15 PM
	/Medic		BEATRICE  4a. Fecility Name (If not institution, give	street and numbe	S.		Location of Death	TED	4c. Cour	2004	7. 13 1
	Lxaiiiii	CI	LEVINDALE HEBREW			BALTIMO	ORE				N/A
	Funeral		5. Social Security Number 6. Se 312-05-9076	X 7. A	ige (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth JAN. 9	Year)	9. Birthple Country	ce (State or Foreign y) T I
	Director		Usuel Residence of Decedent	^	67			UAN. 3,	1917		″ IL
	show	į.	10a. State 10b. County		10c. City, Town or L					100	d. Inside City Limits
	the Mg	Director	MD N/A		BAL	ΓIMORE		-	IOn Citizana	f Milhan Carmen	1 √ Yes 2 No
	death with the Maryland rms 23a or 28a-f show rmust be notified at	Dir	2106 CARTERDALE	ROAD		10f. Zip Code	21209		rog. Ollizeri o	f What Countr	J.S.A.
	death	Funerai	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		ace - Americal	n Indian,
21215-0036	n 72 hours after death with the Marylan *nature!; or ttems 23e or 28e-f show salical Examilinar must be notified at	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates	No	1 ☐ Yes 2 🔀 No	Specify:	rican, etc.,	Spec		NHITE
15-0	n 72 h	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa	lurina most of worki	ing	16b. Kind of	Business/Indu	stry
12	withir ene. than	omp	Elementary/Secondary (0-12)	College (1-4o	(5+)	DO NOT use retired			NURSI	NG EDUC	CATION
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,			
ylar		ToE	LOUIS		STE	RN	LENA			ARMAL	.OFSKY
Maryland	12 sh hand 7 is m traum		19a. Informant's Name/Relationship (7 DAVID I. MILLER			ng Address (Street a					
-	s 1 and 2 should if Heaith and Mer item 27 is marke other traumatic		20a. Method of Disposition		20b. Place of Dispo	S CARTERDA psition (Name of	TCDAEL D			O City or Tow	
E C	000		1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		MI KRO KOI	matory or other place DESH BETH	2/8/	2004	BALT	IMORE,	MD
Baltimore,	permit. Pag Department Important: h eny injury o		21. Signature of Funeral Service Licen	Punt		2. Name and Addres					
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	dications that cause	ed the death. Do not en					1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	A	cute P	nlmon	ary E	demo			Onset and Death
#K	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	+ +	JU.				4
	<b>6</b>	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):	( lear)	allease			-   \	Jeans.
	acuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						`	J
8760,	ate be executed hysician and the burial-transit	ical Ex	resulting in death) Last	Due to (or a	s a consequence of):						
9	ing phy as th		IF FEMALE:			-					
Вох	death certifical e attending phi d for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy				ate of delivery fonth D	yay Year
P.0.	0 0 0	ysic	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9□ Unknown	at time of death 5	Other (specify)					
	requires that the veen signed by th hould be detache	by Pt	Part II. Other significant conditions co	ntributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use co	ntribute to the	cause of death?
ord	w require been sig should t							1 🗆 Ye	es 2 No	3 Probab	oly 4 Unknown
Records,	e law has t	Completed						24a. Was a autops perforr	y	. Were autops prior to comp death?	y findings available pletion of cause of
	ician: The li certificate ha rector, page (	e Co	25. Was case referred to medical		3.00		26. Place of Death	1 ☐ Yes	2D No	1 ☐ Yes 2	□ No
į	S 0 1	To B	examiner?	Hospital: 1 ☐ Inpai	ient 2 ER/Outpatie	nt 3 DOA Othe				ther (Specify)	
o uo	ding After fune		27. Manner of Death  1 Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of In (Month, D	ury 28b. Time o ay Year) Injury	Work	at 2	28d. Describe ho			
Division of Vital	deal ctor. y the	Certification:	2 ^Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of li building,	njury - At home, farm, sti etc. (Specify)			28f. Location (St City or Town		nber or Rural F	Route Number,
×	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical Exam	iner: On the basis	t of my knowledge, deat of examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca	ause(s) and r	nanner as stat	ed. ne cause(s)
~	o the o the omple	Med	29b. Signature and title of certifier	and manner s	, stated.	29c. License	number	2	9d. Date sign	ed (Month, Da	ay, Year)
)	/^		A. Thay	mm		Print) * evind	70000	40	Feb.	06,	2004
	Y		30. Name and address of person who c	mpleted cause of	death (Item 23a) (Type	Print) *	ale				
	Sta		31. Date filed (Month, Day, Year)	32, Regis	trar's Signature						
1:	Registr	9	FEB 1 1 200	4	- 15 A						
DH	MH 17 Rev 1/2	001		do.	ORIGIN	AL					

			1 - For Amend Item 23a p	State of Ma er Dr., G828,	aryland / D ,02/11/04d	eparti lab Certif	ment of H	lealth a Death	and M	ental Hyg	giene Reg. No.	200	+ 04039
			1. Decedent's Name (First, Middle, Las							2. Date of Dea	ith		3. Time of Death
	Physici		Stephen Allen Man	key, Jr.					$\mathbf{F}$	ebruary	Day	2004 Year	11:30A M
1	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4t	o. City, Town, or	Location o				County of Dea	
	ZAGIIII		Laurel Regional H	lospital		L	aurel				P	rince G	eorges
	Funeral		Social Security Number 6. S		(In yrs. last birt		Under 1 Year	If Under 2		8. Date of Birtl	Vaar	9. Bin	thplace (State or Foreign
	Director		027-24-1116	□M 2□F	70	rs.	onths Days	Hours	Min.	1 170671	933		achusetts
	p _		Usual Residence of Decedent										
	arylau show	_	10a. State 10b. County MD Prince 0	Corgos	10c. City, Town	or Location	on						10d. Inside City Limits
	Ba-f	cto		eorges	Laurer								1 ☐ Yes 2 ☑ No
	ii 9	Director	10e. Street and Number			1	10f. Zip Code				10g. Citi	izen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show rmast be rikdiffed at	ē	6101 Brooklyn Brid				207					U.S.A.	
	tam tam	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. Was	Decedent of Hi s, specify Cuba	ispanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- lican, etc.)		<ol> <li>Race - Ame Black, Whit</li> </ol>	
36	orl	by Fi	1 Never Married 2 Married	1 □XYes 2 □ N If Yes, Give	lo	1 🗆	Yes 3 No	Specify:				Specify: W	hite
Ö	filed within 72 hours after Hygiene. other than "natural", or Ita snt, the Medical Exatifie	D D	3 Widowed 4 Divorced	Year or Dates:	100	Dagadant	la Havel Ossuer	ation			10h K		
2	n 72	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		(Give kind	's Usual Occupa d of work done o NOT use retired	lurina most	of workin	g	100. KI	ind of Business	industry
7	withi ene. than	E C	Elementary/Secondary (0-12)	College (1-4or 5		awyer		,			Pri	vate Pr	actice
מ	Hygi Hygi ther int, I		17. Father's Name (First, Middle, Last)		100	wyci		18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
a	0 = -	o Be	Stephen Allen Mar	key, Sr.						h Aller		,	
Maryland 21215-0036	mari mari	2	19a. Informant's Name/Relationship (T		19b.	Mailing A	ddress (Street a	and Numbe	r or Rural	Route Numbe	r City o	r Town State	Zin Code)
<u>8</u>	d 2 s th ar 27 ls trau		Mary F. Markey, Wi				ooklyn						
တ်	es 1 and 2 should build build build Health and Menta item 27 is marked rother traumatic sy		20a. Method of Disposition		20b. Place of	Dispositio	n (Name of			ate		cation - City or	
altimore,	permit. Pages Department of I Important: If it any Injury or o		1 Burial 2 Cremation 3 1		cemeter	y, cremato	or other place Cremat		/10/	2004		rel, Ma	
	ntani njuri		*4 □ Donation 5 □ Other (Specify, 21. Signature of Pluneral Service Dicense		Dare .			-					•
Ba	permit. Departr Imports any Inju			moi	250	22.140	ame and Addres	s or racing	Fle	ck Fune	ral	Home,	Inc.
			23a. Part1. Enter the disease, or comp									el, Mar	yland 20707
1			shock, or heart failure. List only of	ine cause on each lin	10.	ot enter th	ie mode or dying	y, such as t	Gardiac or	respiratory an	esi,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pneumo:	nia								5 days
	/Medical Examiner		Tosulary in doubly		a consequence o								3 years
п		er	Sequentially list conditions,	0	tion Cer		Vascular	Acc1.de	ent	•			6 days
7	ed sit	nine	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury										-
	and and I-trar	Examin	that initiated events resulting in death) Last	C.	al Vascu a consequence o		Acciden	t-			_		3 years
8760,	be exician ician buria			200 10 (01 20 1	# 001100 Que1100 G	.,,							
87	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d									
×	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy								
ВОХ	atten for u	ian	in the past 12 months?	1 ☐ Live birth	2 Fetel death		opic pregnancy				2	23d. Date of del Month	Day Year
o	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	ume or death	5 LI Oth	ner (specify)						
٦.	that the		Part II. Other significant conditions co	ntributing to death bu	it not resulting in	the under	lving cause give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
Vital Records,	be be	d by	Ischemic Cardiom		•		,, ,				es 25		obably 4 Unknown
Ö	w requir been si should	ete		,, , , , , , , , , , , , , , , , , , , ,						-		_	
ě	as s	Completed								24a. Was a autop:	Sγ	prior to o	topsy findings available completion of cause of
<u>=</u>	: The cate ha	Ö									2KXNo	death? 1 ☐ Yes	2 🗆 No
<u> </u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			04			(Check only or			
0	Phys this al dir	2	1 162 5 X140	1 (X) Inpatiei	nt 2 ER/Out		B DOA	4 ☐ Nur				Other (Spec	cify)
<u></u>	ding I h. After funer	Certification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Ti	jury	28c. Injury Work			3d. Describe h	ow injury	y occurred	
SIC	Attending in death.	icat	2 Accident investigation 3 Suicide 6 Could not be	One Pleas of laiv				res 2□N		M 1 10 10		444	
Division	r te	iti	4 ☐ Homicide determined	28e. Place of Inju building, etc	(Specify)	m, street,	factory, office		20	City or Town			ral Route Number,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in		20a Cartillas 453 autitus at	ricion, T. th. Last	d may be a late	ala c c t							
	Hos 24 ho Fun fely f	edical	29a. Certifier 1 ★ Certifying Phy (Check only one)	sicien: To the best of iner: On the basis of	examination and	Vor investi	curred at the tim gation, in my op	e, date and inion, death	d place, ar h occurre	nd due to the c d at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To the It within 24 You the It complete	Med	29b. Signature and title of certifier	and manner sta	ieu.		29c. License					signed (Mont)	
	S 18 1		1	V. 1119	1, -	MI	777	7 -	32		7	1//1/15	£
			MANA	1.1110	m	VIV	V	//7	10		~/	6/0/	
			30. Name and address of person who c Timothy P. McCla					St T	21170	1 ма о	070	7	
	- C	•	31. Date filed (Month, Day, Year)		r's Signature		COLECS	эс. п	aur e.	-, riu Z	070		
	Sta Registr		FEB 1 1 2004	Also a	B. An	Mary.							

			1 - State of Ma		epartment Certificate			ental Hy	giene 20	04 04040
	Physici	an	1. Decedent's Name (First, Middle, Last)	4				2. Date of De Month	Day	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give street and number)	<u> </u>	4b. City, T	own, or Lo	ecation of Death	Febru	4c. County	2607
	Examir	ıer		Hospita	2 1	Bal	HMOR	6		
	Funeral Director		21607 1558 PM 201	(In yrs. last birth	frs. If Under 1 Months		Hours Min.	8. Date of Bir (Month, Da	y, Year 17	Birthplace (State or Foreign Country)
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town						10d. Inside City Limits
,	ith the Marylan or 28a-f show	Director	Maryland	Bal	.timore					1 ⊠ Yes 2 □ No
2	with th		10e. Street and Number 1808 Briarcliff Road		10f. Zip (	2123	34		10g. Citizen of V Uni	what Country? ted States
Joseph	death	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decede	ent of Hispa	anic Origin? (Spe Mexican, Puerto I	cify Yes or No Rican, etc.)	o- 14. Rac Blac	e - American Indian, ck, White, etc.
Von	Baltimore, Maryland Z1Z13-U030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show may injury or other traumatic event. The Medical Exameter must be resulted at ODEs.		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N  3 ☑ Widowed 4 ☐ Divorced Year or Dates:	0	1 ☐ Yes 2		Specify:		Specify	White
L	n 72 ho	letec	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual (Give kind of work life. DO NOT use	done duri		ng	16b. Kind of Bu	usiness/Industry
1:	V1Z1Z	Completed by	Elementary/Secondary (0-12) College (1-4or 5-	Li	neman.				West	ern Electric
	and Z Jbe filed Inta! Hygid ed other	Be	17. Father's Name (First, Middle, Last) William Leo Norton			18	3. Mother's Name Ada Ann		, Maiden Sumam L	ne)
200	aitimore, Maryiand mit. Pages 1 and 2 should be fit partment of Health and Mental H portent: If Item 27 Is marked out y injury or other traumatic even &e.	٦	19a. Informant's Name/Relationship (Type, Print)		Mailing Address					
3	e, M 1 and 2 Health Pm 27 I ther tra		Gloria Russell - Niece  20a. Method of Disposition	20b. Place of	Ruth Av	e of	Copy Copy	, Mary.		City or Town, State
En	Pages nent of little li		1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State  '4 ☐Donation 5 ☐ Other (Specify)	cemeter	y, crematory or oth Wash. Cr	ner place)	ory 2/11	/04		, Maryland
> :	Departition once.		21. Junally of f Funery Seques Licensee	MAHZ	Bradley 2134 Wi	Adress AShi 11ow	ton Matt	hews Fi	uneral H Dundalk,	ome, Inc. Maryland 21222
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do n	not enter the mode	of dying, s	such as cardiac o	r respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ische			roke		2 2	
1/	Examiner		NO. OF THE PROPERTY OF THE PRO	consequence of Cons	on: Lestiv	e	hear	t to	lecre	
V	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	a conseque ve c	of):			4		
,	8 / 60, sate be executed obysician and the burial-transit	Exar	that initiated events c.	a consequence o	of):					
İ	68/60, cate be ex physician the buria	dicai	d							
•	BOX 68 eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of the property o		3 □Ectopic pre	anancy				te of delivery
(	VISION Of VITAL RECORDS, P.O. BOX 68/6U, Attending Physicien: The law requires that the death certificate be executed refash. The first filer this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown		5 Other (spe				Мо	nth Day Year
1	Division of Vital Records, P.O. I or Attending Physicien: The law requires that the datter death. Director: After this certificate has been signed by the Jin by the funeral director, page 2 should be detached.	ģ	Part II. Dther significant conditions contributing to death but	. 0	the underlying ca	use given	in Part I.		3.7	ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
	COTGS, P	ieted	dia beter h	noll:	fr. 5 +	0.60	2	1 🗆 24a. Was	~	1,411-0-170-0-1-1-1-1
1	The lay	Completed	0-10000103 77	W 00 1	( )	The		auto	psy prmed?	Were autopsy findings available prior to completion of cause of death?
	Vita	Be	25. Was case referred to medical examiner?			Other	6. Place of Death			
,	g Phys er this eral di	n: To	27. Manner of Death 28a. Jate of Injury			lc. Injury at Work?			idence 6 Oth how injury occurr	
	SIOF tendin leath. tor: Aft the fun	catio	2 Accident investigation		М	1 🗆 Yes	s 2 🗆 No	206 Location	(Ctroot and Alumbi	os os Rusal Routa Mumbos
	DIVI	Certification:	4 Homicide determined 286. Place of Injured building, etc.	(Specify)	rm, street, factory,	опісе		City or To	wn, State)	er or Rural Route Number,
	DIVISION Of VITAL He Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1X Cartifying Physician: To the best of and manner sta	examination and	e, death occurred a d/or investigation,	t the time, in my opin	date and place, a ion, death occurre	and due to the ed at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)
	To the within:	Me	29b. Signature and tille of certifier		O 29c.	License n	umber	25	29d. Date signed	d (Month, Day, Year)
			Acisanyh :	DUCTO	2	KE	5000		Feb,	07, 2004 MD
			30. Name and address of person who completed cause of de Dr. 1908 Astsaturov, 56	atn (item 23a) (	H Raven	Bou	elevard,	Balt	MORE,	MD
	St Regist	ate	2001	r's Signature,	Spark	11				
	negisi	rai	FEB 1 1 2004	10	jujiona	Park .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 26, 18:35 <sup>™</sup> Raymond W. Newhouse JANUARY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** CUMBERLAND
If Under 1 Year If Under 24 Hrs. MEMORIAL HOSPITAL ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Days Hours 10XM 2□F 83 Director 232-26-3832 14,1920 West Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Director WV Mineral Keyser 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 500 Carskadon Lane, Apt. 611 26726 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Lumber Company n and Mental Hygie Heavy Equipment operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental F Newhouse Sallie Ethel Biser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau sucs. Darlene Doris Newhouse/Wife 500 Carskadon Lane, Apt. 611 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 31 \* 4 ☐ Donation 5 ☐ Other (Specify) Beaver Run Cemetery 2004 Burlington, WV 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home Brean Keyser, WV 85 S. Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial /Medical Due to (or as a consequence of): Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical the 200 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Alter this certificate has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Alter this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 5 Pending 1 Natural Jan<sub>2</sub>4 2004 11:00AM 1 ☐ Yes 21 No investigation 2 Accident Pt slipped on ice 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Parking lot 500 Carskadon Ln Keyser W Va 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D51379 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOM F., M.D., 625 KENT AVENUE, SUITE 209, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 1 1 2004

			State of Maryland / Department of Health and Menta	
			1 - State Certificate of Death	Reg. No. 2004 04042
	Physici /Medic Examir	cal	CAROLYN K. Nutwell Fe	e of Death  th  Day  Year  2004  4c. County of Degth
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	o of Birth noth, Day, Year) 20, 1937  9. Birthplace (State or Foreign Country) Washington, DO
	e-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  MD  Anne Arundel  Annapolis	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 217 S. Southwood Avenue 21401	10g. Citizen of What Country? USA
920	within 72 hours after death with the Maryland ane. than "natural", or Items 23s or 28e-1 show the Medical Evandar must be notified at	þ	3 □ Widowed 4 □ Divorced   If Yes, Give   1 □ Yes 2 型 No Specify: Year or Dates:	s or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	within 72 ho lene. Than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Teacher	16b. Kind of Business/Industry  Education
yland 2	should be filed and Mental Hygis marked other tumatic event, L	To Be C	17. Father's Name (First, Middle, Last) Clarence Kenney Evelyn You	Middle, Maiden Sumame) inkman
	1 and 2 Health a em 27 Is ther tre		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route  George M. Nutwell, Sr. (Husband) 217 S. Southwood Avenue  20a. Method of Disposition  1 Burial 2XX remation 3 Removal from State	
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		I Donar 2111 Control of Control o	04 Baltimore, MD
760,	ate be executed  Nysician and Inspirit ansit  Nysician ansit  Nysician ansit  Nysician ansit  Nysician ansit  Nysician ansit  Nysici	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
P.O. Box 68	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø whomown
tal Records,	icien: The law requ certificate has been ector, page 2 shouk	Be Completed		a. Was an autopsy performed?  Yes 2 No 1 Yes 2 No 1 No 1 No 2 No 2 No 2 No 2 No 2 No
Division of Vital	ding Phys T. After this funeral dis	Certification; To B	2 1 No Hospital: 1 □ Inpatient 2 区 ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □	Residence 6 Other (Specify) scribe how injury occurred
Divi	To the Hospitel or Attent within 24 hours after deatt To the Funerel Director: completely filled in by the			ation (Street and Number or Rural Route Number, or Town, State)
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I	Medical	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1□ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due of the course of the course of the time, date and place, and due of the course of	to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
<b>)</b>	13		30. Nam, and address of person who complete value of death (Item 23a) (Type, Print)	.
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- d1055

			1 - For State Registrar	State of Ma	ryland		artment of H		ind M	F	Reg. No. 2	004	04043
2	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last     CLIFFORD      4a. Facility Name (If not institution, give	JOHN		VELS	SON 4b. City, Town, or	Location of		2. Date of Dea Month February	D	Year 2004 of Death	3. Time of Death 9:55 P M
200	Funeral	lei	7701 Woodmont Ave 5. Social Security Number 6. S	enue Apt. 6	(In yrs. la	ast birthday)	Bethes If Under 1 Year Months Days		4 Hrs.	8. Date of Birt	h	gome:	ry lace (State or Foreign try)
	Director		577-60-0739 1  Usual Residence of Decedent  10a. State 10b. County	XM 2□F	87	Yrs.		7,0010		Oct. 12	1916	111:	Lnois Od. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of the Health and Hygiene. Department of the hygiene. Department of the Hygiene.	Funeral Director	MD Montgome  10e. Street and Number  7701 Woodmont Ave	. Apt. 601		thesda	10f. Zip Code 20814	in ania Orio	i=2 (C==		10g. Citizen of	What Coun	
-0036	hours after de tural, or item	ed by Fund	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  15. Decedent's Ec	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	16a. Decer	Vas Decedent of Hi Yes, specify Cuba Yes 2 X No ent's Usual Occupa	Specify:			Specif	ck, White, iy: V	etc. Vhite
Baltimore, Maryland 21215-0036	filed within 72 Hygiene. ther then "ne int, ILe Medic	Completed by	(Specify only highest gra  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)		-)	(Give life. L	kind of work done of DO NOT use retired Orney	during most )				of Ju	ıstice
larylan	2 should be t and Mental I is marked of eumatic eve	To Be	John Augustus Nel			19b. Mailin	g Address (Street a	Jose	ephi	ne Lest	rade		Code)
nore, N	Pages 1 and ent of Health nt: If item 27 y or other tr		Mary E. Nelson –  20a. Method of Disposition  1√ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	St.ce	ace of Dispo metery, cren Franc	Fairmon	e) P S	D	ate	a, MD 20c. Location Kilmar		wn, State
Batti	permit. F Departme Importer eny injur	_/	21. Signature of Funeral Service Licen	2000	0	22	Ch. Cem. Name and Addres Currie Fi 116 Churc	s of Facility uneral	l Hor	ne lmarnoc	k. Viro		
4	Physician /Medical		23a. Parti. Enter the disease, or comp shock or heart failure. List only immediate/Cause (final disease or condition resulting in death)	one cause on each line	<b>)</b> .		er the mode of dying				rest,		Approximate Interval Between Onset and Death
	icate be executed.  physicien and is the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a									
P.O. Box 687	The law requires that the death certificate be execute the has been signed by the attending physicien and bage 2 should be detached for use as the burial-trans	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o  1 Live birth 2  4 Pregnant at t  9 Unknown	Fetal	death 3□	Ectopic pregnancy Other (specify)					te of delive	ry Day Year
ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions o	ontributing to death but	not resul	lting in the ur	derlying cause give	en in Part I.		23e. Did to	-/		e cause of death? ably 4 DUnknown
Division of Vital Records,	etcten: The law is certificate has builinector, page 2 sh	Completed	OF Wassers of a section of the last								med? 2 No	prior to con death?	osy findings available npletion of cause of 2 No
<u>=</u>	Phyetcle this certi al directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 E	R/Outpatien	3 DOA Othe	26		(Check only or ne 5 Resid		er (Specify	)
sion o	After After funer	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			28b. Time of Injury		rat c? Yes 2 ∐ N	lo		ow injury occur		
N O	To the Hospital or Attent within 24 hours after deati To the Funeral Director: complately filled in by the		4 Homicide determined	28e. Place of Injur building, etc. ysician: To the best of	(Specify)	)		ha data an		City or Tow	n, State)		Route Number,
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exan	iner: On the basis of e and manner state	examinati	on and/or inv	estigation, in my op	oinion, death	occurre	d at the time, o	date and place,	and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier			971	29c. License	. ,	<b>&gt;</b> 5	-9	29d. Date signe	a (Month, L	Jay, Year)
	(0		30. Name and address of person who	completed cause of de	ath litem	23a) (Type,	Print)			sin Ave	Bethe:	sda 1	MD.
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1	32. Registrar	Signatu	ure //	Angell 8	1 -			Doone		

		•	1 - For State of Maryla	•	artment of F		Mental Hygie Reg.	200	4 04044
	Physicia		1. Decedent's Name (First, Middle, Last)	P	almer		2. Date of Death Month FEDRUGE	Day 9, 20	ar 9.40 A M
	/Medic Examin	er	4a. Facility Name (It not institution, give street and number) The Johns Hopkins Hos	Pital	4b. City, Town, o  Bulti  If Under 1 Year	MORE  If Under 24 Hrs.	8. Date of Birth	4c. County of D	
h	Funeral Director		452-40-7057 ¹™™ 2□F 73	s. last birthday) Yrs.	Months Days	Hours Min.	Nov 27 1	930 S	Birthplace (State or Foreign Country) l'exas
	Aaryland f show	ō	Ida agaza in	City, Town or Lo			7		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number		10f. Zip Code	T 4660	10g.	. Citizen of What	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Medical Examinar must be notified at injury or other traumatic event, it a Medical Examinar must be notified at 29.	by Funeral I	7072 Division Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin	54660 lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A	ed States American Indian, White, etc. White
21215-0036	vithin 72 hour: ine. ihan "natural" ihadical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word)	king 16	Bb. Kind of Busine Healt	
and 2	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, Le M.	Be	17. Father's Name (First, Middle, Last)	CIIII	cal Psyc	18. Mother's Nan	ne (First, Middle, Mai Elizabeth	iden Sumame)	11
Maryland	2 should and Men and Men is marke raumatic	ဥ	Gary Palmer  19a. Informant's Name/Relationship (Type, Print)  Julie Palmer / Wife			and Number or Ru	ral Route Number, Comah, Wisc	City or Town, Sta	
	Pages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition 20b 1 □ Burial 2 □ Cremation 3 ☑Removal from State	p. Place of Dispo cemetery, crer	osition (Name of matory or other pla	сө)	Date 20	c. Location - City	y or Town, Stete
Baltimore,	permit. Pages Department of Important: If i any injury or once.	1	*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensea	22		ss of Facility Hi	7/2004 <u>To</u> ubbard Fun ue, Baltim	eral Ho	
	Physician		23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final				·		Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a cons	equence of):	211.2				12 ways
8760,	icate be executed physician and s the buriat-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a cons						
O. Box 6	death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at 1 ☐ Live birth 2 ☐ Fregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnanc	у		23d. Date of Month	f delivery Day Year
Δ.	sign d be	by	Part II. Other significant conditions contributing to death but not of a conditions contributing to death but not of the conditions condit	resulting in the u	underlying cause gr	ven in Part I.			te to the cause of death?  Probably 4  Unknown
Vital Records,	The ate h page	Completed					24a. Was an autopsy performe	prior	
Vita	sician: certific rector,	o Be (	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2	2 ☐ ER/Outpatier	nt 3□ DOA Ot	200	ath (Check only one)		Specific
ō	Jing After fune	H-	27. Manner of Death  28a. Date of Injury  (Month, Day Yeer)	28b. Time o	of 28c. Inju	ry at	28d. Describe how		Орвану
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (Stree City or Town,	et and Number o State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical O	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my to the best of my to the best of examiner: On the basis of exam and manner stated.						
	To the verbill To the comp	2	29b. Signature and title of certifier	- 300	29c. Licen	se number	290	I. Date signed (A	Month, Day, Year)
,	1		30. Name and address of person who completed cause of death (I	Item 23a) (Tuna	Print)	9700AP	te	bruury	4, 2004
	P		30. Name and address of person who completed cases of death (i		oudur .	Bultimo	- Maryla	212	-31-2410
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	gnature	books	R	· ·		

		1 - For	State of Marylar		ent of Health and ate of Death		2004 U	4045
Physi	cian	Registrar  Decedent's Name (First, Middle, Last	)	J	a intto	2. Date of Death Month Da	y O Year /	ne of Death
/Med	lical	4e. Facility Name (If not institution, give	street and number)	4b. 0	Lity, Town, or Location of Dea	repruury	County of Death	53 PM
Exam	iner	The Johns Ho	olines Hosp	rital B	affinere	City	WA	
Funera Directo		5. Social Security Number 6. 96	7. Age (Inlyrs.	Yrs. Mont	hs Days Hours Min		9. Birthplace (Sta Country)	. 1
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location			10d. Insid	le City Limits
death with the Maryland rms 23a or 28a-f show	ctor	Ad N/A	15	altimor				Ŷes 2□No
with the	Funeral Director	1700 M. Can	st.	10f.	Zip Code 21213	10g. Cit	tizen of What Country?	
or death	unera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Do	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - American Indias Black, White, etc.	n,
27275-UU36 within 72 hours after death with the Marylan jene. r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 27 No If Yes, Give Year or Dates:	1 ☐ Ye	s 2 No Specify:		Specify: Blade	
72 hours a natural, c	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's t	Jsual Occupation work done during most of wo T use retired)		ind of Business/Industry	
C 2727 filed within Hygiene. ther then ont, the Mer	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurs		14	eatth Ca	re
E Baby	o Be (	17. Father's Name (First, Middle, Last)	istophen		18. Mother's Na	me (First, Middle, Maider	Edwards	
Maryle d 2 should th and Mer th and Mer traumatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Add	ess (Street and Number or R			V /
- 5 4 7 5		20a. Malhod of Disposition		Place of Disposition (		Date, 20c. Le	Specific A City of Toym, Stet	e fork
0 0		1  Burial 2  Cremation 3  F	removal from State	seL:N Ce	metery 2/1	4/2004 612	den New	Irsy
Baltimo permit. Pag Depurtment Important: i		21. Signatore of Funeral Service Licens	May land	Car	and Address of Parkity	lase Fue	& Service	PA
		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	ications that caused the dea	th. Do not enter the	node of dying, such as cardia	c or respiratory arrest,		Between
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	Seps	15			Unset (	and Death
Examine		Convertibility acaditions	Due to (or as a consect	quence of):	ver Diót	205e	14	ear
/ pel ist	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):				
ate be executed hysician and the burial-transit	Examln	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
68 /60, ifficate be ex g physician as the burial	dlcal	(	d					
Geath certificate e attending physical for use as the	an/Me	230. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		c pregnancy		23d. Date of delivery	
	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o				Month Day	Year
det the	by Ph	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	ng cause given in Part I.	23a. Did tobacco	use contribute to the cause	
Hecords, he law requires t e has been signe							No 3 Probably 4	
age Pa	Completed					24a. Was an autopsy performed?	24b. Were autopsy finding prior to completion death?	of cause of
Of VITAL Physician: The This certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1			ath (Check only one)		
Phys rathis	n: To	27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3□ 28b. Time of	DOA 4 Nursing 28c. Injury at Work?	Home 5 Residence		
OIVISION or Attending after death. Director: After in by the fune	catlo	1 Accident 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
DIVISION  at or Attending s after death. I Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route ! e)	Vumber,
To the Hospital or within 24 hours af To the Funeral D com, letely filled in	edical C	(Check only Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death occur ation and/or investiga	red at the time, date and plaction, in my opinion, death occ	e, and due to the cause(s urred at the time, date and	and manner as stated. d place, and due to the cau	se(s)
To the within 2 To the comple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	100	te signed (Month, Day, Yea	ir)
,			com Ph.O., A		KES-000	teb	ruary 9.20	204
0		30. Name and address of person who or Lynette M. Brown	,	m 23a) (Type, Print)	Wolfe Str	cet Balt	imere MD	21297
S Regis	tate strar	31. Date filed (Mostle-Bay, Year) 20	32 Registrar's Sign	ature	29			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month PRICE **Physician** endALe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner ALTIMORE mediCAL If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Yea If Under 1 Year Months Days 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Country) Virginia ₩ 2□ F 69 Yrs. 218-30-6278 Nov 4, Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No VA Funeral Director Augusta Crimora 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 129 Country Estate Blvd. 24431 USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiena. Important: If them 27 is marked other than "natural" any injury or other traumatic event 12. Was Decedent Ever in U,S.
Armed Forces?
121 Yes 2 No 1957 to
Year or Dates: 1963 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify. ۵ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Crane Operator 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee Price Flossie May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Gladys Price - Wife 129 Country Estate Blvd. Crimora, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Newport Cemetery 2/9/04 Shenandoah, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Bradley Funeral Home 187 E. Main Street Luray, Virginia Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Preumonia Examiner Due to (or as a consequence of) Physician/Medical Examiner rodermen or Attending Physician: The law requires that the death certificata ba axecuted use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1\_Yes 2 YNc 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 Ø No Director: Aftar this d in by the funeral di 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C
completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

IUN GREENE STREET BALT MORE, MD 21201

Physic	ion	State State Unpended Item#23a,27  1. Decedent's Name (First, Middle, Last)  VYONNE DAIMED		OGI	tincate or	Death	2. Date of Death Month	Day Ye	3. Time o	
/Med		YVONNE PALMER					February	05, 200	6:07	P M
Exami	ner	4a. Facility Name (If not institution, give street a			77	r Location of Deat	h	4c. County of E		
		Bon Secours Hospital  5. Social Security Number 6. Sex	T. Age (In yrs. Ias	t birthday)	Balti		8. Date of Birth	N <sub>2</sub>		or Foreign
Funera Director	_	220-64-3793 1 M 2		Yrs.	Months Days	Hours Min.	(Month, Day, ) 3-23-1		Birthplece (State Country) ARYLAND	ur / ur ur gr/
death with the Maryland ms 23s or 28s-f show		10a. State 10b. County	10c. City,						10d. Inside (	
e Mar	ctor	MD. N/A	BA	LTIMO	RE				1X Yes	s 2 🗆 No
ith th	Oire.	10e. Street and Number			10f. Zip Code		109	g. Citizen of Wha	t Country?	
ath w	ra	2500 BELVEDERE AVE.	-		2121			USA		
, ja 22 2	by Funeral Director	1 Never Married 2 Married 1 ☐	s Decedent Ever in U.S. ned Forces? ]Yes 2 MNo es, Give ar or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∏ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. BLACK	
hours af		15. Decedent's Education		16a. Dece	dent's Usual Occup	ation	10	6b. Kind of Busin		
nin 72	Completed	(Specify only highest grade comp	lege (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo	rking		,	
e lited within al Hygiene. I other then "	mo		0-	NUF	SES AIDE			HEALTH	CARE	
Id be liled ental Hygic ked other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma			_
2 should be and Mental is marked is	10 6	JIMMY ELVIS				LAURA	GARLAND			
Te, Ivial yid s 1 and 2 should ! Health and Men item 27 is marke	4 7	19a. Informant's Name/Relationship (Type, Pri					ural Route Number,			
2 5 E E		TIFFANY NOBLE(DAUGH				ORD RD.	BALTIMORE,			
Definition Pages 1 are Department of Heal Important: If item any Injury or other once.		20a. Method of Disposition  1 Serial 2 Cremation 3 Remova  4 Donation 5 Other (Specify)	from State MT	· ZIC	osition (Name of matory or other place ON CEMETE		3-2004 E		E, MARYL	AND
Dermit. Departr Import		21. Signatur Fineral Service deceses ON	ATHAN D. HI				ILLIPS FUN ST. BALTIN			1217
Medica Examiner Asician and burial-transit	_	Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events  c.	Due to (or as a conseque	nce of						
death certifical death cutifical death certifical death der use as the	Physician/Medi	in the past 12 months?	es, outcome of pregnanc Live birth 2 ☐ Fetal d Pregnant at time of dea Unknown	eath 3[	Ectopic pregnanc	/		23d. Date of Month	delivery Day	Year
requires that the	þ	Part II. Other significant conditions contributing	ng to death but not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did toba	.,	te to the cause of	
VICAL INCOOLUS sician: The law requires certilicate has been sign irector, page 2 should be	ompleted						24a. Was an autopsy performe	prior	e autopsy findings to completion of h?	available cause of
_ F 86	e Co	25. Was case referred to medical				0	112 Yes 2	□ No 125	Yes 2□ No	
s cert	o B	examiner? 1 Yes 2 No	l: 1 ☐ Inpatient 2 ☐ EF	R/Outnaties	nt 3 DOA Oth	or.	ath (Check only one) Home 5 Residen		Speciful .	
nding Phy th. : After this	tlon: T	27. Manner of Death 28a	Date of Injury 2 (Month, Day Year)	8b. Time o Injury	f 28c. Injui	y at	28d. Describe how		opecny)	
or Attending after death.  Director: After tin by the fune	Certification:	3 ☐ Suicide 6 🛣 Could not be determined 28e	. Place of Injury - At hom building, etc. (Specify) und in house				28f. Location (Stre City or Town, 1803 N. Pul	State)	or Rural Route Nui	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica	Medical C	29a. Certifier  (Check only 2 Medicel Exeminer: Only 1 Certifying Physicien: 2 Medicel Exeminer: Only 1 Certifying Physicien: 0 Certifying Physicien:	To the best of my knowl	ledge, deat and/or in	h occurred at the till vestigation, in my o	me, date and place	e, and due to the cau	ise(s) and manne	or as stated.	
o the	Me	29b. Signature and title of certifier			29c. Licens	e number	296	d. Date signed (M	fonth, Day, Year)	
- ≤ - ō		Jousta & Street	spen N	S		O.C.M.E	E. F	ebruary	06, 2004	4
		30. Name and address of person who complete	od cause of death (Item 2			reet Rai	ltimore, M	larvland	21201	
		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		, remi 96	Leet, Da.	LLHIOLC, P.	TATA TOTAL	7170T	
S	tate									

	1	For State Registrar			partment of F ertificate of				Reg. No.	2004	0404
/sicia	n	1. Decedent's Name (First, Middle, La						2. Date of De Month	Day	2004	3. Time of Death 2:30 PI
ledica	af _	Reginald E. Robey			4b. City, Town, o	v. Logation	of Death	Februa		County of Deal	
amine		ta. Fecility Name <i>(If not institution, giv</i> Hilltop House	e street and number)		Clarksv		OI Death		ļ	vard	
eral		5. Social Security Number 6. S		n yrs. last birthda	ay) If Under 1 Year		24 Hrs.	8. Date of Bi	th Voor)	9. Bir	thplace (State or Fore
tor		216-12-8711	1 <b>₹</b> M 2□F	80 Yrs	Months Days	Hours	Min.	Month, Di April 6	192	23 Mã	ryland
	-	Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or	Location						10d. Inside City Lim
B C B	_	Maryland Anne Aru		Glen B							1 ☐ Yes 2 🕏
Trout	rec.	10e. Street and Number	andor		10f. Zip Code				10g. Citiz	en of What Co	ountry?
87 18	a D	165 S. Meadow Dr:	ive		21060				Unit	ed Stat	tes
E U	by Funeral Directo	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	3. Was Decedent of I If Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spen, Puerto	ecify Yes or N Rican, etc.)	D- 1	4. Race - Ame Black, Whit	
aggin L	Y Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 □ No If Yes, Give		1 ☐ Yes 2 No					Specify: Wh	nite
al Ex		15. Decedent's E	Year or Dates:	16a. De	cedent's Usual Occup	pation			16b. Kin	d of Business	
Siraly	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(G	ive kind of work done  e. DO NOT use retire	during mos	st of work	ing			,
Dec 1	E	8	College (1-401 5+)	T	ruck Drive	r			Trai	nsporta	ation
Vent	Be	17. Father's Name (First, Middle, Last	")					e (First, Middle		Sumame)	
any injury or other traumatic event, the Medical Exactine must be notified at once.	2	Walter G. Robey						. Deitz			7.0.4
raum		19a. Informant's Name/Relationship		1	ailing Address (Street			al Route Numb	er, City or	Town, State,	Zip Code)
ther		Carole Hardingham  20a. Method of Disposition		20b. Place of Di	S. Meadov sposition (Name of		/e Febru	Pate-tz	20c. Loc	cation - City or	Town, State
y or o		1 ☐ Burial 2 🗵 Cremation 3 [			crematory or other pla rematory	(0)	10, 2	_			e, Marylan
in in	ŀ	*4 □ Donation 5 □ Other (Special Signature of Turneyal Service Lice			rirkiey-Ru						21061
eny ir		A Hotel	X		Kirkiey-ku 421 Crain						Maryland
Maga Control		23a. Part1. En er than isease, or con shock, or heart lailure. List only	nplications the caused th		The state of the s				the same that property on the		Approximate Interval Between
ian		Immediate Cause (Final disease or condition		PMam	nis-						Onset and Death
ical		resulting in death)	Due to (or as a c							-	10771001
ner											
	-	Sequentially list conditions,	b. Due to for so a								
nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury	b. Due to (or as a c	onsequence ol):		,					
al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b. Due to (or as a co			,					
e burial-transit	Ехап	that initiated events	с			,					
ng eu	Icai Exam	resulting in death) Last	с			,					
ng eu	Icai Exam	IF FEMALE: 23b. Was decedent pregnant	c	pregnancy	3 □Ectopic pregnanc				2	3d. Date of de	
ng eu	Icai Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 24No	c	pregnancy		.y			2	3d. Date of de Month	olivery Day Year
ached for use as the bu	Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	pregnancy Fetal death ne ol death	3 □Ectopic pregnanc 5 □ Other (specify) _		I.	23e. Did		Month	Day Year
be detached for use as the bu	by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 24No	c	pregnancy Fetal death ne of death	3 □Ectopic pregnand 5 □ Other (specify) □ ie underlying cause gi	ven in Part	ı.			Month se contribute t	Day Year o the cause of death
should be detached for use as the bu	by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions	c	pregnancy Fetal death ne of death	3 □Ectopic pregnanc 5 □ Other (specify) _	ven in Part	ī.		tobacco us	Month se contribute t	Day Year o the cause of death' robably 4  Unknow utopsy findings availa
ye 2 should be detached for use as the bu	ompieted by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	pregnancy Fetal death ne of death	3 □Ectopic pregnand 5 □ Other (specify) □ ie underlying cause gi	ven in Part	I.	1 🗆 24a. Wa auto perf	Yes 2 s an oppsy ormed?	Month se contribute t No 3 P  24b. Were a prior to death?	Day Year o the cause of death' robably 4 Ulnkno utopsy findings availa completion of cause
page 2 should be detached for use as the bu	e Compieted by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	pregnancy Fetal death ne of death	3 □Ectopic pregnand 5 □ Other (specify) □ ie underlying cause gi	ven in Part		1 🗆 24a. Wa auto perf	Yes 2 san opsy ormed?	Month se contribute to the secontribute to the secontribute to the second to the secon	Day Year o the cause of death' robably 4 Unknow utopsy findings availa completion of cause
director, page 2 should be detached for use as the bu	Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	c	pregnancy Petal death not resulting in th	3 □Ectopic pregnand 5 □ Other (specify) □ ie underlying cause gi	ven in Part	e of Deat	24a. Wa autr per 1 Tyes h (Check only ome 5 F-Res	tobacco using the san opsy ormed? 2 No one)	Month se contribute t  No 3 P  24b. Were a prior to death? 1 Yes	Day Year of the cause of death' robably 4 [Unknown utopsy findings availate completion of cause s 2 No
al director, page 2 should be detached for use as the bu	To Be Completed by Physician/Medical Exam	## The state of t	Due to (or as a condition of the control of the con	pregnancy Petal death not resulting in th	3 Dectopic pregnance 5 Other (specify)  e underlying cause granted and the of 28c. Injury	26. Place ther: 4 \( \sum \) No at ork?	e of Deat	24a. Wa auto peri 1 Yes	tobacco using the san opsy ormed? 2 No one)	Month se contribute t  No 3 P  24b. Were a prior to death? 1 Yes	Day Year of the cause of death' robably 4 [Unknown utopsy findings availation of cause s 2 No
al director, page 2 should be detached for use as the bu	To Be Completed by Physician/Medical Exam	## To the past of	C. Due to (or as a condition of the cond	pregnancy   Fetal death ne of death not resulting in th	3 DEctopic pregnand 5 Other (specify) is underlying cause grant attient 3 DOA is of 28c. Injury M 1	26. Place ther: 4 Ni	e of Deat	24a. Wa autroped 1	tobacco us Yes 25 s an ppsy ormed? 2 No one) idence 6	Month  se contribute t  No 3 P  24b. Were a prior to death? 1 Yes	Day Year of the cause of death' robably 4   Unknown utopsy findings availate completion of cause is 2   No
by the funeral director, page 2 should be detached for use as the bu	To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   2 No 9   Unknown  Part II. Other significant conditions    Chistian	Due to (or as a condition of the conditi	pregnancy   Fetal death ne of death not resulting in th	3 Dectopic pregnance 5 Other (specify)  e underlying cause granted and the of 28c. Injury	26. Place ther: 4 Ni	e of Deat	24a. Wa auto per 1 1 Yes h (Check only ome 5 € Res 28d. Describe	tobacco us Yes 25 s an ppsy ormed? 2 No one) idence 6	Month se contribute t No 3 P  24b. Were a prior to death? 1 Yes  Contribute t A Number or A	Day Year o the cause of death? robably 4 Unknow utopsy findings availa completion of cause
ely filled in by the funeral director, page 2 should be detached for use as the bu	Certification; To Be Completed by Physician/Medical Exam	that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions    Continued	Due to (or as a condition of the conditi	pregnancy   Fetal death ne of death not resulting in th  2   ER/Outpa  (ear)   28b. Tim Inju  At home, larm (Specify)  my knowledge, deamination and/o	3 DEctopic pregnand 5 Other (specify)  a underlying cause grant  attent 3 DOA  a of 28c. Injury  M 1 Course  attent, street, factory, office	26. Place ther: 4 Ni	e of Deat dursing Ho	24a. Wa autroped 1 Ves h (Check only ome 5 1 Res 28d. Describe 28f. Location City or To	tobacco use Yes 2 5 s an opsy ormed? 2 No one) idence 6 how injury (Street and own, State) e cause(s)	Month  se contribute to the co	Day Year  o the cause of death' robably 4   Unknot utopsy findings availate completion of cause s 2   No ecify) Asst.
ely filled in by the funeral director, page 2 should be detached for use as the bu	To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   2   No 9   Unknown  Part II. Other significant conditions    Continue   Continue	Due to (or as a condition of the conditi	pregnancy   Fetal death ne of death not resulting in th  2   ER/Outpa  (ear)   28b. Tim Inju  At home, larm (Specify)  my knowledge, deamination and/o	3 Ectopic pregnand 5 Other (specify) is underlying cause given the office of the office offic	26. Place ther: 4 Ni	e of Deat dursing Ho	24a. Wa autroped 1 Ves h (Check only ome 5 1 Res 28d. Describe 28f. Location City or To	Yes 2 s an ppsy ormed? 2 No one) iidence 6 how injury (Street and wm, State) e cause(s), date and	Month  se contribute t  No 3 P  24b. Were a prior to death? 1 Yes  Cocurred  Number or A  and manner a place, and du	Day Year  o the cause of death?  robably 4   Unknown  utopsy findings availate completion of cause is 2   No ecrity) Asst. I
pletely filled in by the funeral director, page 2 should be detached for use as the bu	edical Certification; To Be Completed by Physician/Medical Exam	## Total Indicated events resulting in death) Last  ### IFFEMALE:  ### 23b. Was decedent pregnant in the past 12 months?  ### 1	Due to (or as a condition of the conditi	pregnancy   Fetal death ne of death not resulting in th  2   ER/Outpa  (ear)   28b. Tim Inju  At home, larm (Specify)  my knowledge, deamination and/o	3 Ectopic pregnand 5 Other (specify) is underlying cause given the property of	26. Place her: 4 Ni	e of Deat lursing Ho No nd place, ath occur	24a. Wa autroped 1	Yes 2 s an oppy ormed? 2 No one) idence 6 how injury (Street and www., State) a cause(s), date and	Month  se contribute to the co	Day Year  o the cause of death' robably 4   Unknot utopsy findings availa completion of cause s 2   No  ecify) Asst.  dural Route Number, s stated. e to the cause(s)
ely filled in by the funeral director, page 2 should be detached for use as the bu	edical Certification; To Be Completed by Physician/Medical Exam	## Total Indicated events resulting in death) Last  ### IFFEMALE:  ### 23b. Was decedent pregnant in the past 12 months?  ### 1	Due to (or as a condition of the best of t	pregnancy   Fetal death ne ol death  2   ER/Outpa  28b. Tim Inju  At home, larm (Specify)  my knowledge, d kamination and/od.	3 DEctopic pregnance 5 Other (specify) and the control of the cont	26. Place her: 4 Ni	e of Deat lursing Ho No nd place, ath occur	24a. Wa autroped 1	Yes 2 s an oppy ormed? 2 No one) idence 6 how injury (Street and www., State) a cause(s), date and	Month  se contribute to the co	Day Year  o the cause of death? robably 4 Unknot utopsy findings availa completion of cause s 2 No  ecify) Asst. 1  dural Route Number, s stated. e to the cause(s)  th, Day, Year)

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician FEBRUARY** 6, 2004 **JESSICA REISBOARD** 2:00 A M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARMONY HALL ASSISTED LIVING COLUMBIA HOWARD If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 0CT.11,1912 If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Min 1□M 2☑F Hours 91 Yrs. 059-09-7421 Director Usual Residence of Decedent 10a. Slate 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No HOWARD COLUMBIA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 CEDAR LANE #225 21044 U.S.A. Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. illed within 72 hours after 1 ☐ Never Married 2 ☐ Married 0 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: 3 

Widowed 4 □ Divorced Year or Dates: 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be + pe t Mental if Health and Menta GOLDBERG JOSEPH 1 **TANENBAUM** 2 ANNA Peges 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9005 EL MONTE WOODS WAY - ELLICOTT CITY, MD 21042 BARBARA LISLE / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) PARK 20a. Method of Disposition 20c. Location - City or Town, Slate ₽ <u>₹</u> 1 X Burial 2 Cremation 3 X Removal from State Department of Important: If any injury or once. S ☐ Other (Specify) KING SOLOMON MEMORIAL 4 Dona 2/8/2004 CLIFTON, NEW JERSEY uneral Servic 21. Signa 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alumus DISCOME team monker, resulting in death) /Medical Due to (or as a consequence of) Examiner ingstu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ rell 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 22 No certificate 1 Yes 2 No Division of Vital ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 No Other: 4 \( \sum \) Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To funeral dir 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 ☐ Suicide in by t Place of Injury · Al home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide ö the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number 0 30. Name and ad ess of person who completed cause of death (Item 23a) (Type, Print) Chulmo, my DI Bun purquet 221 51 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For Stete Registrar	_	State of Ma	ryland / [	Department <i>Certificate</i>	of Health and of Death		Reg. No.	4 04051
	Physici			e (First, Middle, Las 2el Roloff					2. Date of De Month		3. Time of Death
	/Medic Examin		4a. Fecility Name ( FRANK 5. Social Security N 244-28-5	Number C6. Se	ARE HOS	piTA   fin yrs. last bir 76	Ro.	own, or Location of Dea Sear If Under 24 Hi Days Hours Mil	ath	4c. County of I  BA17  inth ay, Year)  9.	Death  I MORE  Birthplece (State or Foreign Country)
	Director		Usual Residence of	of Decedent		10c. City, Tow			July 2	.2, 1927	North Carolina  10d. Inside City Limits
	with the Maryland a or 28a-f show	tor	10a. State MD	Baltin	1	-	Baltimore				1 ☐ Yes 2√ No
	with the	i Direc	10e. Street and Nu	<sub>imber</sub> gene Avenu	ıe		10f. Zip C	ode 21221		10g. Citizen of Wha	t Country?
	)36 irs after death i	by Funeral Director	11. Marital Status	ried 2 Married	12. Was Decedent E Armed Forces? 1  Yes 2 XNe If Yes, Give Year or Dates:			nt of Hispanic Origin? y Cuban, Mexican, Pue	(Specify Yes or N arto Rican, etc.)	<u> </u>	American Indian, White, etc. White
off	ind 21215-0036 be filled within 72 hours after lat Hygiene. d other than "natural", or its event, the Medical Extrator	Completed	(Spe	15. Decedent's Ed cify only highest gra- ondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+		life. DO NOT use	done during most of w retired)		16b. Kind of Busin	
Rol		Be	17. Father's Name	(First, Middle, Last) Lewis Car	rroll		telepho			communic e, Maiden Sumame)	ations
_	Maryla d 2 should th and Men 7 Is marke	To		Name/Relationship (7				Street and Number or			
+ 420	of Hea		20a. Method of Dis	ia Martin/ sposition : □Cremation 3 □ 5 □Other(Specify	Removal from State	20b. Place o	6513 Cork of Disposition (Name iny, crematory or oth	ley Road B	altiшоте Date	20c. Location - Cit	y or Town, State
Manufacture .	Baltimo		21. Signature of	uneral Service Licen Onald S	Wade, Dire	gtor	State A Baltimo	Address of Facility natomy Boar re, MD 21	rd 655 W	. Baltimor	e Street
	Physician /Medical Examiner bhysician and physician the burial-fransit	licai Examiner	23a. Palt 1, Enter shock, or he Immediate Cause disease or conditions and the condition of the conditions of the cause. Enter Und Cause (Disease of that initiated even resulting in death)	an failure. List only of (Final lon) onditions, mmediate berrying or injury ts	bications that caused one cause on each line  a. McTAb  Due to (or as a c.)  Due to (or as a c.)	consequence	Acidos		ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	0 = 0 =	by Physician/Med	IF FEMALE: 23b. Was decede in the past 1: 1  Yes 2 9  Unknow	2 months?	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal death	n 3 ⊟Ectopic pre 5 □ Other (spe			23d. Date of Month	f delivery Day Year
	1S, P.(	by Ph	Part II. Other sign	ificant conditions c	ontributing to death bu	t not resulting	in the underlying ca	use given in Part I.	,	,	te to the cause of death?  Probably 4 Dunknown
	Il Records, The law requires the cate has been signe, page 2 should be considered.	Completed							24a. Wa aut per 1 🗆 Yes	opsy prid formed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \( \sum \) No
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	To Be	25. Was case reference examiner? 1  Yes 2 27. Manner of Dea 1 Natural 2  Accident	ÑNo	Hospital: 1 A npatier 28a. Date of Injur (Month, Day	y 28b.		Othor		r one) sidence 6 □Other a how injury occurred	(Specify)
	Divisited or Attental or Attental or Attender all Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc	ry - At home, f . (Specify)	arm, street, factory,	office	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one)	†⊠ Certifying Ph ∠ Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination a	ge, death occurred a nd/or investigation,	t the time, date and pla n my opinion, death or	ice, and due to th courred at the time	e cause(s) and mann e, date and place, and	er as stated. I due to the cause(s)
•	To th within To th comp	Me	29b. Signature an	time of sertifier	M		29c.	License number	96	29d. Date signed (	Month, Day, Year) 2004
	St Regist	ate rar	DR. JASO 31. Date filed (Mo	onth, Day, Year)	completed cause of de AUM 900 32. Registra	eath (Item 23a)  FRAA  ur's Signature	(Type, Print)	FUARE DA	BA17	imore N	Month, Day, Year) 2004  1d, 21237

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** OBERTS MARIAN FEBRUARY 08 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOSPITAL BALTIMORE BON SECOURS If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 □ M 58 Yrs. Director 238-70-5767 Oct 23, 1945 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2013 Wilkens Avenue 21223 Funeral United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Restaurant College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If item 27 Is marked other the any injury or other traumatic avent, Item once. Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Roberts Cora Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Marvin Roberts-Son 2013 Wilkens Avenue, Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Feb 13 4 □ Donation 5 □ Other (Specify) Mount Zion Cemetery 22. Name and Address of Facility Baltimore, MD 2004 21. Signature of Funeral Service Licensee Lound. A Calvin L. Williams Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** CORONARY DISENSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed HYPERTENSION the attending physicien and Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No OBSTRUCTIVE 24a. Was an autopsy certificate 1 🗌 Yes 2 1 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier-D30272 miller FEBRUARY 08 2004 address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

Dockson home (First Moths Law)   A lexical Management of Suskidavics   A lexical Management of Control of Suskidavics   A lexical Man				1 - For State Registrar	5	State of	Marylan		artmen <i>rtificat</i>				1ental		ene 2	004	O manufacture	050
The control of the co		50.00	**		Last)											Year		
Security teachers  Financial Directory  Financial D				Alexander		Sus	skawicz	Z 					Febr	ary			7:45	5 P <sup>M</sup>
TOTATION OF THE PROPERTY OF TH			er	-				tation	Wes	tmin	ster					arroll		
The state of the s													8. Date (Mont Dec.	of Birth h, Day, 1	1913	Coun	try)	r Foreign
To provide the provided of the		and *					10c. Cit	ty, Town or Lo	ocation							1	0d. Inside Ci	ity Limits
To provide the provided of the		Aaryla f sho	ō	Maryland Howa	rd			Je:	ssup								1 🗆 Yes	<b>2</b> ₹₹₩0
To provide the provided of the		the the 286-	rect	10e. Street and Number						Code				109	g. Citizen o	of What Coun	itry?	
To provide the provided of the		3a or	ā	7968 Dorsey Run	Roa	ıd				2079	4			1	Unite	d Stat	es	
To provide the provided of the		death ms 2	nera	11. Marital Status	12			l.S. 13.	Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes	or No-	14. R	ace - Americ	an Indian,	
To provide the provided of the	980	urs after al', or Ite	by Fu		d	1 ☐ Yes :	2 🔀 No						Tioan, or	J.,				
To provide the provided of the	Š	2 hou	ted	15. Decedent'	s Educa	tion		16a. Dece	dent's Usu	ai Occup	ation	st of work	rina	10	6b. Kind of	Business/Ind	dustry	
To provide the provided of the	218	thin 7	ple	Elementary/Secondary (0-12)	grade c		4or 5+)	life.	DO NOT	se retired	1)	31 31 1137	9		Lilco	2		
Peter Stakkmyloz  Peter Stakkm		ed wi	Son					<u> </u>	Meter	Rep		- 1- 1	- /5: 1	Caladia AA				
A common	pu	be fill d off	Be		ast)						_		_		alden Sum	атө)		
A common	∑ Se	J Mer J Mer Jarke Jatic	ိုင		Tuna	- Oriet)		10b Maili	na Addros	/Street				-	City or Tow	m State Zin	Code	
A common	<u>a</u>	12 st hand 7 is n traun					27°		,									
A common		1 and Healt am 2				augrice	20b. F	Place of Disp	osition (Na.	me of								
Physician / Medical Examiner  Physic	ğ	ages nt of t: If it		1 Burial 2XX remation		noval from S	tate	_	-			2/1	5/04	т	່ລນກດີ	l Mars	bac Itt	
Physician / Medical Examiner  Physic	Ē	artme artme ortent injury													.aure.	L, Mal	утапа	
Physician / Medical Examiner    Physician / Medical Examiner	Ba	Dep in being any any and		M. Pah				2	7250 V	vasiii	urma	n Fu n Bl	neral va.	. Hon Elkr	ne At idae	MMP., Marv	Inc.	21075
Sequentially list conditions are unappropriated to the past 12 months   Due to (or as a consequence of):				shock, or heart failure. List of	complica inly one	tions that ca cause on ea	used the deat ach line.	th. Do not en	ter the mod	de of dyin	g, such as	s cardiac	or respirat	ory arres	st,		Interval Bet	lween
Sequentially ist conditions.  Sequen	Į.			disease or condition	a				musi	Sino							1 pay	2
Constitution of the property o	1			,		Due to (d	or as a consec	quence of):										
Constitution of the property o		was sign	ē	Sequentially list conditions, if any, leading to immediate	b	Due to (d	or as a consec	quence of):										
Temporary   Temp		uted d ansit	F	Cause (Disease or injury														
FFEMALE:   23d. Date of delivery   23d. Date of deli	Ó	exection and an and rial-tra	Exa	resulting in death) Last	G.	Due to (d	or as a consec	quence of):										
FFEMALE:   23d. Date of delivery   23d. Date of deli	176	ite be iysicië ne bu	Icai		d													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	9	ng ph	a a	IE EEMAI E							<del>.</del>		· · · · · · · · · · · · · · · · · · ·		7	1		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	õ	ith ce itendi	an/l	23b. Was decedent pregnant	230	1 ☐ Live bi	rth 2 🗆 Feta	al death 3			,						,	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	_	e des the at	sici	1 ☐ Yes 2 ☐ No				death 5[	Other (s	oecify)				<del></del>			,	
Page 17 Completion of cause of death?    All Page 2   No.   Page 3   No.   Page 3		- 0 0	P <sub>h</sub>	-	ns contr	ibuting to de	ath but not res	sulting in the u	underlying	cause div	en in Part	l.	23e.	Did toba	acco use co	ontribute to th	ne cause of d	death?
24. Was an autopsy performed autopsy autopsy autopsy autopsy autopsy autopsy performed autopsy performed autopsy performed autopsy performed autopsy a	ds,	signe d be d				<b>3</b>			, , , ,					1 🗆 Yes	2 □ No	3 ☐ Prob	abiy 4 🖼	Unknown
PRINCIPLE AND A CONTROL OF THE	Š	requ been shoul	ete										243	Was an	24	. Were auto	nsy findinas	available
29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Rec	e la has je 2	dm											autopsy	ed?	prior to con death?	mpletion of c	ause of
29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	<u>a</u>	n: Th ficate ir, pa		26. Was seen referred to madical							OC Diag	o of Doo				1 ∐ Yes	2∐ No	
29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Ę	sicie : certi irecto	8	examiner?	Но	spital:	natient 2	TER/Outpatie	nt 3[] D	OA Oth						Other (Specifi	v)	
29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	o		<b> -</b>	27. Mannef of Death				28b. Time o									,,	
29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	ion	nding ith. :: Afte	at lo			(MOnti	n, Day rear)	injury				]No						
29a. Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Vis	Attar ir dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could n		28e. Place	of Injury - At h	nome, farm, si	reet, factor	y, office						mber or Rura	I Route Num	iber,
29a. Certifier (Check only one)  29a. Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29c. License number  29d. Date signed (Month, Day, Year)  20d. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  20d. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  20d. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ö	safte safte al Dir ed in	Cert	Tomesas /		Dollar	19, 010. (0,000.	.,,,										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John C. Abel, M.O. 295 Storer Are Suite 307 westminster, MD 21157		Hospi 4 hour Funeri ely filli		(Check only 2 Medical I		r: On the ba	isis of examina											5)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John C. Abel, M.O. 295 Storer Are Suite 307 westminster, MD 21157		thin 2 tha 1 mplet	Med		-	and mann	er stated.		29	c. Licens	e number			29	d. Date sig	ned (Month.	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John C. Abel, M.O. 295 Storer Are Suite 307 westminster, MD 21157		T V V	-	235. Signature and title of certifier	ph	1C. Ne	elm	_				943			_			24
John C. Abel, M.O. 295 Stoner Are Suite 307 westminster, MD 21157				- (/					Drine\			-					,	*
The Marth Carl Word Constitute Constitute		12								<u> </u>	Scite	30	7	Nest	mins	ter, N	10 21	157
	17	St	ate	0 /	1	-				-	, ,					<u> </u>		

	- :		For State Registrar	State of Mar	yland / De	partmen	t of Health and e of Death	Mental Hy	giene 2 Reg. No.	_	04051
	Physici	an	<ol> <li>Decedent's Name (First, Middle, La Joan B. Stan</li> </ol>					2. Date of De	Day	Year	3. Time of Death
	/Medio	_	4a. Fecility Name (If not institution, give		9	4b. City.	Town, or Location of Dea	Februs		onty of Death	0.3314
	CXdIIII	eı	11 4 6	vore Ho	Spital	Ko	001.	6	Bo	inty of Death	MOLP
8	Funeral		5. Social Security Number 6. S		In yrs. last birthda	Months			h Year	9. Birth	place (State or Foreign
***	Director		215-30-9856 Usual Residence of Decedent		70 Yrs.			pury 20	, 195	Mary	Land
	yland		10a. State 10b. County	1	0c. City, Town or	Location				1	10d. Inside City Limits
	Ba-fal	ctor	Maryland Baltin	nore	Dt	ındalk					1 □ Yes 2 🖹 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: if Item 27 is marked other than "netural", or Itama 23a or 28a-f ahow miportant: if Item 27 is marked other than "healtest Examere must be notified at ance.	Completed by Funeral Director	109. Street and Number 103 Willow Spring	g Road		10f. Zip	21222		_	of What Cour ed Stat	
	ama arm	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	3. Was Deced	dent of Hispanic Origin? ( cify Cuban, Mexican, Pue	Specify Yes or No	- 14.1	Race - Americ Black, White,	
215-0036	ours afte	1 by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:			2⊠ No Specify:				White
5-00 5-00	72 hc natu	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De (Gi	cedent's Usua ve kind of wo	ai Occupation rk done during most of wo	orking	16b. Kind o	f Business/In	dustry
) —	within ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		anager	se retired)		Apartn	ment Co	omplex
d 2	Hygid Hygid Other	Be Cc	17. Father's Name (First, Middle, Last	)		214901	18. Mother's Na	ame (First, Middle,			<u>F</u>
$k \in V$ Maryland	should be nd Mental marked o	To B	Mearl Agnew Wills					Jackson			
¥ar ∠	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (Charles Riley - S				(Street and Number or F ystone Drive		-		
ore,	of Head of Item		20a. Method of Disposition	30	20b. Place of Dis	position (Nar	ne of hther place)	Date	20c. Location	on - City or To	own, State
Ç Ë	Page ment c ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	60)			Cemetery 2/	/13/04	Balti	imore,	Maryland
S T Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lice	18 Und	MAHZ	22. Name ar Bradle 2134 W.	nd Address of Facility Y—Ashton—Mat illow Spring	thews Fu Road I	neral undal:	Home,	Inc. yland 21222
68760,	Physician / Medical Examiner physician and physician and the price transit the price transit physician and physici	dicai Examiner	23á. Parti. Ente fhe disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of the control of th	static consequence of): Carc	_ •	e of dying, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Box	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death	3 □Ectopic pi 5 □ Other (sp			23d.	Date of delive Month	ery Day Year
s, P.O.	es that I gned by be deta	by Ph	Part II. Dther significant conditions	contributing to death but	not resulting in the	underlying o	ause given in Part I.				he cause of death?
ord	een s	ted						1/2	res 2□N	o 3 ☐ Prob	pably 4 □Unknown
Rec	The law ite has b	Completed						24a. Was autor perfo 1 \( \text{Yes} \)	an 24 osy rmed? 2 No	b. Were auto prior to co death? 1 \( \subseteq \text{Yes}	opsy findings available impletion of cause of
ital	ian: rrtifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o			2010
>	Physician: rthis certification, ral director, ral	10	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient				Home 5 ☐ Resid	dence 6 🗆	Other (Specif	ý)
Division of Vital Records,	ath. r: After t	ation:	27. Manner of Death  1	28a. Date of Injury (Month, Day )	(eer) 28b. Time Injur	ool 2 y M	Rec. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	now injury oc	curred	
Divis	Hospital or Attanding 14 hours after death. Funeral Diractor: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		/ - At home, farm, (Specify)	street, lactor	y, office	28l. Location (S City or Tox	Street and No vn, State)	imber or Rura	al Route Number,
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Proceedings one 1 Certifying Proceedings on the certified Procedure of the	hysician: To the best of miner: On the basis of e and manner state	xamination and/or	ath occurred investigation	at the time, date and place, in my opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and pla	manner as s ce, and due to	tated. the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier			290	. License number		29d. Date sig	gned (Month,	Day, Year)
	,		D416				D61104		2	10/04	
	10		30. Name and address of person who	completed cause of dea	1 6 63	10	Roll	imore, 1	10 71	7 7	
100	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar		a, e b	we soul	imore, 1	IV XI	25/	
	Regist	120	EVER 4 2004	ha . Day	4	1					

		1	For State Registrar	State of Ma	ryland	-	rtment o			F	eg. No.	004	04055
	Physician	1	1. Decedent's Name (First, Middle, Last Donna Jean Silver							2. Date of Dea Month Februa	Day	Year 004	3. Time of Death  11:15 a M
	/Medica Examine	-	Ba. Facility Name (If not institution, give Gilchrist Center		ce Ca	are	4b. City, Tow	Tows	son		4c. County Balti	more	
15 AM	Füneral Director		5. Social Security Number 6. Se  217. 64. 3836 10  Usual Residence of Decedent	X 7. Age		49 Yrs.	If Under 1 Y Months Da	ear If Und ays Hour	der 24 Hrs. s Min.	8. Date of Birth (Month, Day May 15	, Year)	9. Birthp Cour MD	place (State or Foreign htry)
11	death with the Maryland ms 23a or 28a-f show ms 12a or 28a-f show		10a. State 10b. County  MD Baltimo			Town or Loc						1	0d. Inside City Limits 1 Yes 21 No
40/	with the	DILEC	10e. Street and Number 3907 Putty Hill A	Venue			10f. Zip Co				10g. Citizen of V		-
6/	or Ita	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Endred Forces?  1  Yes 2 No If Yes, Give Year or Dates:	ver in U.S			of Hispanic Cuban, Mexi		ecify Yes or No- Rican, etc.)		e - Americk, White,	ean Indian, etc.
ŏ	ithin 72 hour ne. han "natural	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	-)	(Give life. L	ent's Usual O kind of work d OO NOT use n	ccupation one during n etired)	nost of worki	ing	16b. Kind of B Constru	usiness/In	dustry
Warvland 21215	uld be filed w dental Hygier rked other ti tic event, Ith	lo Re Col	17. Father's Name (First, Middle, Last)  Jesse Donald Sil	verthorn		ACCOL	intant			(First, Middle, Elizabe			
orn	d 2 shouth and No. 17 is maintreumail		19a. Informant's Name/Relationship (7) Mr. Damian C. Sil		Son					al Route Numbe			Code)
Silvertho Baltimore.	ages 1 an ant of Heat it: If Item 2 y or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Pt	ace of Dispo emetery, cren	sition (Name of natory or other .ke Cre	of r place)		Pate Feb 8 2004	20c. Location ·	City or To	
S, IV. Baltir	permit. P Departme Importan any Injur		21. Signature of Funeral Service Licens			22	. Name and A Cremat	ddress of Fa	clity d Fune	eral Alt	ernati	/es	1 = 0.00 EANs-T
£/209.	ite be nysicia he bui	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a d.	consequ	ence of):	lun	S Ca	hce/			3	nonths
O. Box 68	death cer e attendin id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 thenths? 1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 9 \( \subseteq \text{ Unknown} \)	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the second control of the seco	2 🗌 Fetal	death 3	Ectopic pregr Other (specif					te of deliventh	ery Day Year
<u>α</u>		۾	Part II. Other significant conditions co	ontributing to death bu	t not resu	ilting in the u	nderlying caus	se given in Pa	art I.		es 2 No		he cause of death? pably 4 DUnknown
l Reco	The law requir ate has been si page 2 should I	Completed									sy med?	Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of 2 No
Division of Vital Becords.	r Attending Physician: There death. rector: Atter this certificate by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined		Year)	ER/Outpatien 28b. Time of Injury me, farm, str	28c.	Other: 4 ☐ Injury at Work? 1 ☐ Yes 2	Nursing Ho	me 5 Residence R	ence 6 COth	red	y) Hospice
	urs urs erel	edical Cer		ysician: To the best o niner: On the basis of and manner stat	examinat								
		Med	29b. Signature and title of certifier	and manner stat	180.			icense numb			29d. Date signe		-
	10		30. Name and address of person who of		eath (Item	23a) (Type,	Print)	Sycal	5 5	F Ba	lteman.	ry7	2004 2004
1	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 1 208	32 Registra	ur's Signa		with s			,			- 51204

	1 - For State Registrar AMFND ITFM #18 ]  1. Decedent's Name (First, Middle, Last)	State of Maryland	<sub>/04</sub> Gertific	ate of L	Death		Reg e of Death	, No.		3. Time of Death
Physician	Jeannette Sellman	า				Mo	nth	Day y 10,	Year 2004	5:20 P N
/Medical Examiner	4a. Facility Name (If not institution, give st			City, Town, or	Location of	f Death		4c. County		
	Gilchrist Center			ider 1 Year	TOWSO		- of Diah	Balti		(Ctata as Fassis
Funeral Director	5. Social Security Number 6. Sex 1 1	M 252F 7. Age (In yrs. I.	79 Yrs. Mon		Hours	Min. (Mo	e of Birth nth, Day, Y	1924	Count MD	ace (State or Foreig try)
70	Usual Residence of Decedent									NA Laste Obstanta
parmit. Pages 1 and 2 should be littled which 2 indus sites destined the interview of pages. Department of Health and Mental Hydroxidation of Health and Mental Hydroxidation in the many injury or other traumatic event, the Medical Erani, ear must be notified at once.  To Be Completed by Funeral Director	10a. State 10b. County		, Town or Location						10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
28a-f	MD Baltimor	e To	wson 10f	. Zip Code			100	g. Citizen of V	Vhat Coun	try?
Sa or	2 Dixie Drive			21204			1	United	Stat	es
in arrivant be notified in arrival be notified in arrival be notified in arrival by the contract of the contra	11. Marital Status	2. Was Decedent Ever in U.: Armed Forces?	S. 13. Was D	ecedent of Hi	ispanic Orig	jin? (Specify Ye , Puerto Rican,	s or No-		e - America	
V Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		s 20 No	Specify:		,	Specify		
al Erain	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	16a. Decedent's	Usual Occupa	ation		16	6b. Kind of Bu	White siness/Ind	
t, the Mutical f	(Specify only highest grade  Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind o	f work done o T use retired	durina most	of working				ernment
E O	Elementary/Secondary (0-12)	2	Manager							
event.	17. Father's Name (First, Middle, Last)					r's Name (First,				
o natic	Herman Barnes	and the second	19b. Mailing Add	vana (Ctrant	Mary					Code)
traum	19a. Informant's Name/Relationship (Type Andrew Sellman/Son					y Ave.,				
other	20a. Method of Disposition	20b. P	Place of Disposition emetery, crematory			Date	20	Oc. Location -	_	
יף סר	1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	nesapeake			Feb 2004		Beltsv	ille,	MD
any inju	21. Signature of Funeral Service License		22. Nam	e and Addres	ss of Facility	y Funeral	A1+6	ernati	7es	
<b>a a</b>	Styllet Xohn	name	87	17 Gree	en Pas	stures I	rive	Balt.		
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death e cause on each line.	h. Do not enter the	mode of dyin	g, such as	cardiac or respi	ratory arres	st,	8	Approximate Interval Between Onset and Death
ician	Immediate Cause (Final disease or condition resulting in death)	Munple	Myel	oma					3	jears
dical niner		Due to (or as a consequ	uence of):							_
<u>a</u>	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uenca ol):						-11	
Examiner	Cause (Disease or injury that initiated events c.									
urial-t	resulting in death) Last	Due to (or as a consequ	uence of):						Į.	
the burial-transit	d									
d by the attending printershed for use as the letached for use as the printershed for use as the physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna						23d. Da	te of delive	ory
d for t	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		r (specify)				Мо	nth	Day Year
tache	9 ☐ Unknoyvn	9 Unknown								-
9 9		tributing to death but not res	ulting in the underly	ing cause giv	en in Part I.	, 23	le. Did toba 1 ∐ Yes	<b></b>	ribute to th	ne cause of death? ably 4 □Unknow
should be de							<del>-</del>			
2 0 0							a. Was an autopsy perform	ed?	prior to cor death?	psy findings availab mpletion of cause of
or, page					26 Place	of Death (Chec		72 -	Yes	2
After this certific funeral director,	examiner?	ospital: 1   Inpatient 2	ER/Outpatient 3	DOA Oth	or	rsing Home 5	ALC: NO		er (Specify	Nospice.
eral o	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	28d. De	escribe hov	w injury occur	red	11007100
ne fur	Natural 5 Pending investigation	(	М		Yes 2					
n by ti	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		ctory, office			cation (Street) or Town,		er or Rura	il Route Number,
To the Funeral Director: Attert completely filled in by the funeral Madical Certification.	One Contiling Physics	ician: To the best of my kno	owledge death occu	urrod at the tir	me date an	d place, and du	e to the car	use(s) and ma	nner as si	tated
etely f	29a. Certifier Certifying Phys (Check only 2 Medical Examination	ner: On the basis of examina and manner stated.	ation and/or investig	ation, in my o	pinion, dea	th occurred at the	ne time, da	te and place,	and due to	the cause(s)
omple Somple	29b. Signature and title of certifier	0		29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)
	Afra	Lun		DS	830	13	F	CORV	BRY	10 2004
)	30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, Print)	,	0. 5	Baltin		us o	267	~
	Jum J Charles	1099 ans	N-Cho	VES.	711	Daltin	une	WUD	40	04
State	31. Date filed (Month, Day, Year) FEB 1 1 2004	32. Registrar's Signa	ature sealed							

5.30 pm.

	ian	Decedent's Nam		Last)							Mor			Year ,	3. Time of Dea
ledi	cal	4a. Fecility Name (	Arnold	Daw		Shi	pe	45.0	Shy Town o	or Location of D		ruary	lc. County of	-004	06:40
amir	ner	6000 6	amavi	+7111	Hov	init		Po	6141	AAA ice	eath		1/-	A	
eral	П	5.233aL34cu57	Umber 6	5. Sex		Age (In	yrs. last bir	Mont	nder 1 Year	Il Under 24	Hrs. 8. Date	of Birth oth, Day, Yea 26, ]	(r)	9. Birthp	plece (State or Fo
tor	-	Usual Residence of		1 🔀 M :	201		86	Yrs.			Nov.	26, 1	917	West	Virgin
4		10a. State	10b. County			10c	. City, Tow	n or Location						1	0d. Inside City L
Dall	ctor	MD					Balt	imore							1 X Yes 2
20	Dire	10e. Street and Nu		1				10f.	Zip Code	110			Citizen of W	hat Cour	ntry?
ne wedical examinations; se notified at	Funeral Director	6021 Fal	LKITK KO		/as Deced	dent Ever i	nUS	13 Was D	212	IZ Iispanic Origin'	(Specify Ves		JSA 14 Bace	- Americ	an Indian,
Tale of	Fun		ried 2 Marrie	A	med Ford Yes 2 Yes, Give	ces?		If Yes,	specify Cub	an, Mexican, P	uerto Rican, e	tc.)		, White,	
EXSI	þ	3 X Widowed	4 Divorced	If Y	Yes, Give ear or Dat	X. tes:		1 ☐ Ye	s 2 🗓 No	Specify:			Specify:	Wh	nite
2	Completed	(Spe	15. Decedent's cify only highest	Education grade com	n npleted)		16a.	Decedent's U	Jsual Occup work done	pation during most of d)	working	16b.	Kind of Bus	iness/Ind	dustry
No.	d m	Elementary/Sec	ondary (0-12)	С	ollege (1-	4or 5+)		Labor		a)		Ca	rpent	ry	
ent.	Be Co	17. Father's Name	(First, Middle, La	ast)						18. Mother's	Name (First, I	Middle, Maide	n Sumame	))	<del></del>
IIC O	To B	John A.	Shipe							Mabe1	T. Mo	yers			
other traumatic		19a. Informant's N								and Number of					Code)
11 100		Sherrie		- Ni	.ece	- 100				ock Rd.		-			
ō		20a. Method of Dis	sposition Cremation 3	3 □Remov	al from Si	late		Disposition ( ry, crematory			Date	20c.	Location - C	City or To	wn, State
any injury or or			5 Other (Spe	ecify)		R	est F	laven M	1em Gd	ns   2-	-7-04	На	rriso	nbur	g, VA
		23a. Part I. Ester	the disease, or c	officilication	ns that car	used the c	leath. Do i	not enter the r		Greenn			150110		Approximate
ian cal ner		mmediate Cause disease or condition resulting in death)	art failure. List or (Final on	a.	use on ea	ch line.		Can	mode of dyir	Greenn			150119		Approximate Interval Between
ner IIsual-Italian	al Examiner	shock, or hea Immediate Cause disease or condition	art failure. List or (Final on onditions, mmediate erlying irijury	a b	Due to (o	or as a con	~ 9	Canof):	mode of dyir				130112		Approximate Interval Betwee
ner use as the burial-transit	cian/Medical	Sequentially list or days. Enter United Sequentially list or days. Enter Und.	art failure. List or (Final or	a b c d 23c. If	Due to (o  Due to (o  Due to (o	or as a con	sequence sequence sequence	of):	c pregnancy	ng, such as can			23d. Date Mont	of delive	Approximate Interval Betwee Onset and Dea
ner use as the burial-transit	by Physician/Medical	Sequentially list or farmy, leading to in cause. Enter Undurate Undurates United in the interest of the past 12 1 \( \subseteq \text{yes} \)	art failure. List or (Final on	a b c d 23c. If 11 41 91	Due to (o  Due to (o  Due to (o  Ves. outco	or as a conor a con	sequence sequence sequence egnancy etal death	of):  of):  3   Ectopi 5   Other	c pregnancy	ng, such as can	diac or respira	tory arrest,	23d. Date Mont	of delive	Approximate Interval Betwee Onset and Dea
page z should be delached for use as the burial-transit	Completed by Physician/Medical	Sequentially list or farmedises or conditive cause of conditive sulting in death)  Sequentially list or fany, leading to it cause. Enter Undurates (Discussion that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown  Part II. Other signi	onditions, mediate erlying injury start pregnant emonths?	a b c d 23c. If 11 41 91	Due to (o  Due to (o  Due to (o  Ves. outco	or as a conor a con	sequence sequence sequence egnancy etal death	of):  of):  3   Ectopi 5   Other	c pregnancy	ng, such as can	23e	. Did tobacco	23d. Date Mont  use contrit  2 No 3  24b. W pr	of delive	Approximate Interval Betwee Onset and Dear onset an
page z should be delached for use as the burial-transit	Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1	on (Final on (Fi	a b c d 23c. If 11 41 91	Due to (o  Due to (o  Due to (o  Que to (o  Due to (o  Due to (o	or as a conor a conor as a conor a c	sequence sequence sequence sequence sequence retail death of death resulting in	of):  of):  3   Ectopi 5   Other	c pregnancy (specify)	en in Part I.	23e 24a 1□ Death (Check	Did tobacco	23d. Date Mont  use contrit  2 No 3  24b. W pr det det	of delive	Approximate Interval Betwee Onset and Dear Onset an
page z should be delached for use as the burial-transit	To Be Completed by Physician/Medical	Inmediate Cause disease or conditive resulting in death)  Sequentially list or if any, leading to if cause. Enter Unducture in that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  yes 2  g Unknown  Part II. Other signi	on (Final on (Fi	a	Due to (o  Due to (o  Due to (o  Due to (o  Clive bin  Pregnal  Unknow  ting to dea  al: 1	or as a conor as a conor as a conor as a conor at the con	sequence seq	of):  3   Ectopi 5   Other  the underlyin  topatient 3	c pregnancy (specify)	en in Part I.  26. Place of lef: 4 \( \) Nursin	23e 24a 1□ Death (Check g Home 5 □	Did tobacco	23d. Date Mont  Use contrib  2 No 3  24b. W prediction of 1	of delive	Approximate Interval Betwee Onset and Deat onset an
page z should be delached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown Part II. Other signi	on (Final on (Fi	a b c d 23c. If 11 4 9! ss contribut	Due to (o  Due to (o  Due to (o  Due to (o  Clive bin  Pregnal  Unknow  ting to dea  al: 1	or as a conor a conor as a conor as a conor as a conor as a conor	sequence seq	of):  of):  3   Ectopi 5   Other  the underlying	c pregnancy (specify)  DOA Oth  28c. Injur	en in Part I.  26. Place of lef: 4 \( \) Nursin	23e 24a 1□ Death (Check g Home 5 □	Did tobacco	23d. Date Mont  Use contrib  2 No 3  24b. W prediction of 1	of delive	Approximate Interval Betwee Onset and Deat onset an
page z should be delached for use as the burial-transit	ertification: To Be Completed by Physician/Medical	Immediate Cause disease or conditive resulting in death)  Sequentially list or if any, leading to ir cause. Enter Undeath, leading to ir cause. Enter Undeath, leading to ir cause. Enter Undeath, leading in death)  IF FEMALE: 23b. Was deceder in the past 12 1  yes 2 9  Unknown  Part II. Other signi	onditions, mmediate ertying i rigury s Last  ht pregnant months? No ficant condition  rred to medical	a. b. c. d. 23c. If 11 4 9 9 9 9 9 9 9 1 1 1 1 1 1 1 1 1 1	Due to (o  Due to (o  Due to (o  Due to (o  Ves. outcu  Live bin  Pregnai  Unknow  ting to dea  al: 1	or as a conor a conor as a conor a	sequence seq	of):  of):  3   Ectopi 5   Other  the underlying  tpatient 3	c pregnancy (specify)	en in Part I.  26. Place of lef: 4 University at k?	23e 24a 1□ Death (Check g Home 5 □ 28d. Des	Did tobacco  1 Yes  Was an autopsy performed? Yes 2 Nonly one)  Residence cribe how injunctions	23d. Date Mont ouse contribute 2 No 3 24b. Wy of 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of delive	Approximate Interval Betwee Onset and Deat onset an
page z should be delached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 9 Unknowr  Part II. Other signif	art failure. List or (Final on	a. b. c. d. 23c. If I	Due to (o  Live bin  Pregnai  Unknov  ting to dea  al: 1 Ing  a. Date of (Month,  e. Place o building	or as a conor a conor as a conor a c	sequence seq	of):  3   Ectopi 5   Other  the underlyin  tipatient 3    Time of njury M  rm, street, fac	c pregnancy (specify)	26. Place of lef: 4 Nursin yat k? Yes 2 No	23e 24a 1□ Death (Check g Home 5□ 28d. Des 28f. Loca City ace, and due	Did tobacco  1 Yes  Was an autopsy performed? Yes 2 Nonly one) Residence cribe how injuiction (Street a or Town, Sta	23d. Date Monto	of delive the problem of autopion to consult?  Yes  (Specify d	Approximate Interval Betwee Onset and Deat onset
should be detached for use as the buriar-transit	ertification: To Be Completed by Physician/Medical	In mediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Undo Cause. Enter Undo C	art failure. List or (Final on (Final on	a. b c d 23c. If 11 4 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Due to (o  Live bin  Pregnai  Unknov  ting to dea  al: 1	or as a conor a conor as a conor a c	sequence seq	of):  3   Ectopi 5   Other  the underlying  topatient 3    Time of niury M  rm. street, factorian door investigate	c pregnancy (specify)  DOA Oth  28c. Injury  1 Cotory, office	26. Place of lef: 4 Nursin yat k? Yes 2 No	23e 24a 1□ Death (Check g Home 5□ 28d. Des 28f. Loca City ace, and due courred at the	Did tobacco  1 Yes  Was an autopsy performed? Yes 2 N only one)  Residence cribe how injuiction (Street a or Town, Sta	23d. Date Monto	of deliver the substitute of t	Approximate Interval Betwee Onset and Deat on

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item#5perFHG828 2/17/04 FW 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Dey</sup> 2004 FEB. **Physician** ELAINE SCHILDWACHTER 7, 8:15PM HELEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Sykesville Carroll Continuum Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 13, 1922 5. Social Security Number 1166-12-5932 2 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthday) **Funeral** Days Country, Hours 1 M 2 √F 81 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at 1000s. 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County Sykesville 1 Yes 2 No MD Carroll **Funeral Director** 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21784 USA 105 Rockvale Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 δ. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Radio Station Account Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) George Everhart Wyand 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. Frederick Schildwachter 19a. Informant's Name/Relationship (Type, Print) 105 Rockvale Road Sykesville, MD 21784 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 2/11/04 Baltimore, MD HATCHTO FUNERAL HOME & CHAPEL, PA (Box 195) 21. Signature of Funeral Service Licenses Has Sykesville, MD 21784 (410)-795-1400 0 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical nd-Examiner Due to (or es a consequence of): Physician/Medical Examiner 8101 6 9 attending physician and 1 for use es the burial-transit Hospital or Attending Physician: The law requiras thet tha daath cartificate ba axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of resulting in death) Last 23b. Did tobacco use contribute to the cause of death? been signed by the a should be datached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown HIN ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed o god diol has Por colin 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours aftar daath.

To the Funeral Director: After this certific completely filled in by tha funerel director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) Hospital: Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Matural 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Division

State Registrar

0

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

(al)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOI 4412

1 Sparks

230119

Kesville

Krond

				State of Maryland / Department of Health and M  State of Maryland / Department of Health and M  Certificate of Death	lental Hygie	-	+ 04059
				Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
		Physici		Clarence Austin Standiford, Sr.	February	7, 2004	2200 <sup>M</sup>
	5	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	-	4c. County of Dea	
		LAGIIII		Harford Memorial Gardens Havre de Grac	e	Harfo	
		Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day, ) Mar. 13,	<sup>(ear)</sup> 1918 P	thplace (State or Foreign ountry) ennsylvania
		pu 🗼		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
		fanyli sho	ក				1 ☐ Yes ZONo
		28a-1	by Funeral Director	Maryland Harford Havre de Grace  108. Street and Number 107. Zip Code	100	g. Citizen of What C	ountry?
		with a o	₫	122 Darlington Road 21078		USA	
		ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Am	
1	(O	or Iter	Ξ	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No    If Yes, Sive   1 □ Yes ▼□ No Specify:	Hican, etc.)	Black, Whi	White
· ~	5-0036	rel', c	by	3 ⊠ Widowed 4 □ Divorced Year or Dates:		Specify:	
7		n 72 hours after death with the Marylan "naturel", or Items 23e or 28e-f show signal Examinat novel be notified at	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing 16	3b. Kind of Business	/Industry
(-	121	c -	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Morananan	
5	d 21	Hygl Hygl Ither Int,			e (First, Middle, Ma	Newspaper aiden Sumame)	
-	an	e da b	To Be		Alverta	Wilgis	
5	arylan	2 should be to and Mental Is marked oranmatic ever	۲	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	al Route Number, (	City or Town, State,	Zip Code)
	Σ	s 1 and 2 should Health and Men Item 27 is marke other traumatic		Laura E. Standiford / Daughter 735 Marian Drive, Aber	deen, Ma	ryland 21	001
0	re,			20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)  20c. Place of Disposition (Name of cometery, crematory or other place)	Date 20	oc. Location - City or	Town, State
I	E	Pages nent of ant: If It ary or o	8	'4 □ Donation 5 □ Other (Specify) Bel All Memorial Grans 2-1		Bel Air,	Maryland
	Baltimor	permit. Page Department of Importent: If any injury or once.		21. Six ature of Funeral Service Licensee  22. Name and Address of Facility McComas Funeral Ho 1317 Cokesbury Roa	me, P.A. d, Abing	don, MD 2	1009
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line.	or respiratory arres	it,	Approximate Interval Between
3		Physician		Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEART FAILUIT			Onset and Death
6	4	/Medical		resulting in death)  Due to (or as a consequence of):	-		
11/10		Examiner	L	Saquentially list conditions. b.			
0		ed sit	Examiner	S quentially list conditions. If any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
		xecut and al-trar	xan	that initiated events c.  Due to (or as a consequence of):			
00	760	eath certificate be executed attending physician and for use as the burial-transit	calE	d			
0	.89	ificate g phy as the					
4	ŏ	h cert anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	,
١	В.	Physicien: The law requires that the death certifical this certificate has been signed by the attending phy rail director, page 2 should be detached for use as the	by Physician/Medi	In the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
eanance	P.0	that the ded by the detached	Phy	9 Unknown	22a Did toba	coo uso contribute t	o the cause of death?
2	Ś	w requires that s been signed t : should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PNEUMOWA			robabiy 4 Minknown
2	9	raqui paen poulc	eted		24a. Was an		
60	Records,	elaw hast je 2 s	Completed		autopsy performe	prior to	utopsy findings available completion of cause of
7)	ital	icien: The la certificate ha rector, page 3			1 ☐ Yes 2	No 1 □ Ye	s 2□ No
	Ž,	ysiclen: is certific director,	Be	examiner? Hospital:	h (Check only one)	ce 6 □Other (Spe	20(6)
Rd	of	Phys r this ral di	1,10	27. Manner of Death 28a. Jate of Injury 28b. Time of 28c. Injury at	28d. Describe how		scily)
0	on	nding Ph th. : After th s funeral	tlor	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
7	Division	l or Attending atter death. Director: After I in by the fune	iffica	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number.
andiford		pital or Al burs after o lerel Direc filled in by	Certification:				
5	jd	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, dat	e and place, and du	e to the cause(s)
		To the To the Comp	Σ	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mon	th, Day, Year)
		Ĭ.		Municipal 17D 345344	2	18/2004	1
		V		30. Name and dress of person who o'mpleted cause of death (Item 23a) (Type, Print)  SURESH DHAN JANI HD, 6225, UNION AVE, HAVREDE  31. Date filed (Month, Day, Year)  32. Registrar's Signature	COACE	UN OIMTE	
		Sta	to.	31. Date filed (Month, Day, Year)  32. Registrar's Signature	GILTIUE P	IN SIV 18	
		Registi		ance helever to down			

DHMH 17 Rev 1/2001

			For State Registrar AMEND ITEM #1,	State of Maryland	d / Depa 8828 With Cel	artment of 5	lealth and Death		iene 2001	04061
			Decedent's Name (First, Middle, Last)	ANNA TRUTSTSY				2. Date of Death	h	3. Time of Death
	Physicia /Medic		Anna	Trust	5			Februar	Day Year	4 8:47AM
)	Examin	-	4a. Facility Name (If not institution, give s North West Hos	pital Cent	er	4b. City, Town, or Randa	listow	n	4c. County of Dea	BALTIMORE
e	Funeral Director		5. Social Security Number 6. Sex 13-21-9359	M 2 F 7. Age (In yrs. )		If Under 1 Year Months Days	If Under 24 Hr. Hours Min		1909 9. Bir	thplace (State or Foreign puntry) UKRAINE
	p .		Usual Residence of Decedent  10a, State 10b, County	10c Cib	y, Town or Lo	ocation				10d. Inside City Limits
	faryla shov	ō	MD BALTIN			TERSTOWN				1 ☐ Yes 2 No
	28a-	Funeral Director		OPSHIRE COURT	ILLIS	10f. Zip Code		10	0g. Citizen of What Co	ountry?
	h with	al DI	1 <del>26 SHOPSHIRE C</del>				21136			UKRAINE
	deat	ner	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madreal Exemiting must be natified at	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 □Yes 2 🛣 No If Yes, Give Year or Dates:		1 □ Yes 2 🏋 No	Specify:		Specify:	WHITE
2-0	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	durina most of w		16b. Kind of Business	/Industry
121	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired RIETOR	d)		DRY CLEANE	·R
	filed with Hygiene other thai		17. Father's Name (First, Middle, Last)		FROF	KILIOK	18. Mother's Na	ame (First, Middle, A		.IX
Maryland	should be find Mental in marked of	To Be	GERSCH	В	EREJAN		MIRA			IKNOWN)
Mar	2 short and		19a. Informant's Name/Relationship (Type		19b1 Maili	SHROPSHIKE	OOOKID TO F	Rural Route Number,  DETCE	City or Town, State,	Zip Code) 0 21136
	1 and 2 Health tem 27 l		ELLA SHETIN / DAI  20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of		- transfer	20c. Location - City or	
Baltimore	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other place E HEBREW		9/2004	REISTERS	TOWN, MD
ij	그런 발금 .		21. Signature of Funeral Service License			2. Name and Addre		The second secon	SON & BROS	
ä	Depa Impo eny i		/ago		10	8900 REIS				, MD 21208
4	* 2		23a. Part1. Enter the disease, or compli- shock, or heart filture. List only on	cations that caused the deat e cause on each line.	h. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Ischemic	card	iomyop	athy			>5 years
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	/ /	-			> Tuesas
н	2 2/2/4	- L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq		ery disc	ase			> 5 years
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Type, II	diab	etes m	ellitus			> 5 years
o,	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a conseq						
3760,		ical								
k 68	eath certificate attending phys for use as the	Med	IF FEMALE:	Zo If use outcome of program	no.				00d Data at de	
Вох	attend for us	ian/	in the past 12 months?	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of de Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9 Unknown						
<u>α</u>	w requires that the death cer been signed by the attendin should be detached for use	y P	Part II. Other significant conditions cor		- 1	4 2	0 1			to the cause of death?
ord	equire en sig ould b	ted	Dementia // CI	ironic and P	cute	renal t	arlure	1 □ Ye	es 2 □ No 3 □ P	robably 4 Vunknown
Records,	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as if	Completed by Physician/Med	Hypercholesterol	emia // Anen	nieu			24a. Was a autops perforr	y prior to med/? death?	utopsy findings available completion of cause of
a F	n: Th ficate rr. pag		Adeno carcinoma 25. Was case referred to medical	of cecum			OS Plans of D		2☑No 1☐Ye	s 2□No
Vital	Physician: this certific ral director.	To Be	avaminar?	ospital: 1 Inpatrent 2	ER/Outpatie	nt 3 DOA Ott	nac	eath (Check only on Home 5 Reside	ence 6∐Other <i>(Sp.</i>	ecify)
J Of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe ho	ow injury occurred	
ior	Attending r death.	atio	1 Vatural 5 Pending 2 Accident investigation				Yes 2 No			
Division of	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)	reet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
<b>V</b>	To the Hospital or Attendis within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	(Check only 2 Medical Exami	sician: To the best of my knoter: On the basis of examination and manner stated.						
	o the o the omple	Med	one) 29b. Signature and title of certifier	and marrier stated.		29c. Licen			9d. Date signed (Mor	nth, Day, Year)
	F 3 F 8		1 & Boston	MD		02	8462	F	ebruary	8,2004
	2		30. Name and address of person who co		m 23a) (Type					land 21133
4	- C	210	31. Date filed (Month, Day, Year)	32; Registrar's Sign		NI COLLIC	1 1011		1	
	St Regist	ate rar	FFR 1 1 200	Roser &	y day	acket				

		1	For State Registrar	State of M	aryland				ealth a Death	and M		Reg. No.	Z 111110	0406	2
	Physici	an	1. Decedent's Name (First, Middle, Las Dominick	P		V	asco				2. Date of De Month Februa	Day	6,200	3. Time of Death 4 10:16A	
	/Medic Examin	er	4a. Fecility Name (If not institution, give Frederick Memor	ial Hospi	tal		F	rede			0.0	1	Frederi	ck	
7	Funeral Director		5. Social Security Number 6. St 577–30–9254 1  Usuel Residence of Decedent	7. A	ge (In yrs. Ias 76	st birthday) Yrs.	Months	Days	If Under 2	Min.	8. Date of Bird (Month, Da April 4	y, Year) +, 1	927 Was	thplece (State or Fore puntry) hington, I	) . C
	Maryland -f show	tor	10a. State 10b. County Maryland Frederi	ck		Town or Lo								10d. Inside City Lim 1 X Yes 2 ☐ I	
	h with the 23e or 28s	ai Director	10e. Street and Number 833 Dunbrooke	Court				217					izen of What C		
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-f show other than "natural", or items 24e on tilliad at avent, the Medical Examina must be nutiliad at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	?		Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify: Wh	te, etc.	
21215-0036		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+)	life.	dent's Usu kind of w DO NOT U	ork done d ise retired	luring most )	t of worki	ng		ind of Business as Comp		
Maryland 2	should be filed within to Mental Hygiene. marked other than matic avant, the Mental to Men	To Be Co	17. Father's Name (First, Middle, Last)	A. Vasco	)				An	geli	(First, Middle, na Mast	terv	ito		
Mai	alth and 27 is r		19a. Informant's Name/Relationship (19mm) Mrs. Janet H. Vas		lest St	833	Dunbi	ooke	Ct.,	Fre		, Ma	ryland	21701	
Baltimore,	0 0		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specific	')		nce of Dispo metery, crei hsbirg	g Crem	atory	F	eb. 8	, 2004	Sm		g, Marylar	nd
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licental Service Licenta	16	M0025	5	<u> 106 I</u>	Cast	<u>Churc</u>	h St	PA Fun	deri.	1 Home ck, MD	21701 Approximate	
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. My0	cardia s a conseque	(	infa			our diago				Interval Between Onset and Death 3 hours	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b. — Due to (or a	s a conseque	ence of):									
8760,	cate be executed obysician and the burial-transit	Cai	resulting in death) Last	d	s a conseque	ence of):									
.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic   □ Other (s						23d. Date of de Month	olivery Day Year	
٥	juires that the nation of signed by ald be detacted	by	Part II. Other significent conditions of	ontributing to death	but not resul	iting in the u	ınderlying	cause giv	en in Part I.	•	23e. Did t			o the cause of death? robably 4 Unkno	
Records,	ystcien: The law requires that the is certificate has been signed by the director, page 2 should be detache	Completed									24a. Was auto perfo 1 \( \text{Yes}		prior to death?	utopsy findings availa completion of cause s 2 No	ble of
Vital	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	Hospital:				Oth	or:		Check on				-
of	라 는 F	lon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D		R/Outpatie 28b. Time o Injury		28c. Injur Wor	4 LI NU		me 5 ☐ Resi 28d. Describe		6 □Other (Spary occurred	ecify)	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, st					28f. Location ( City or To			lural Route Number,	
_	To the Hospitel or Attendation 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 🕱 Certifying Ph (Check only 2 Medical Examone)	sysicien: To the bes niner: On the basis and manner:	of examination	vledge, deal on and/or in	th occurre	d at the tir	ne, date an pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s date an	) and manner a d place, and du	s stated. e to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier  Parid Yn	чо			2	D D	5819	9			ite signed (Mor	th, Day, Year) 6, 2004	
	10		30. Name and address of person who	310 M	J 9th	St	Print	edenic	le,	MO	217	)			
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu	ure منسعر	6	1	racks	/					

James Williams 04-01040

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Type of Film in Didok indenble ink. Enddre All Cop	nes Are Legible.
State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	ZUU4 II4

	AKG		1 - For State Registrar	Otate of Mary		rtificate of			2004	04063
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	11	. 1.			2. Date of Death Month	Day Year	3. Time of Death
ŗ	/Medic		JAMES	HENR	y W	ILLIA		Februar	y 6, 2004	13:50 PM
_	Examin	er	4a. Fecility Name (If not institution, give s 4404 White Oak	treet and number)	1	Baltimor	or Location of Death		4c. County of Death	/ 4
			5. Social Security Number 6. Sex	7. Age (In	rs. last birthday)	If Under 1 Year		8 Date of Birth	N/	A lace (State or Foreign
ē	Funeral Director			M 2□F	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y AUG- 15,	1924 MA	RYLA
	yland		10a. State 10b. County	10c.	City, Town or Lo	cation			10	0d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show must be multiped st	tor	MARYLAND N/	A		BAI	TIMORE	CITY		1 Yes 2 □ No
	ith the	Directo	10e. Street and Number	2		10f. Zip Code			. Citizen of What Coun	try?
	ath w	rai	00000	ERTY KC	AD		2120		USA	
	after death w	Funerai	11. Maritaf Status 1 1 ☐ Never Married 2 ☑ Married	Was Decedent Ever i Armed Forces?	n U.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
20	be filed within 72 hours after death with the Maryla ital Hygiene. bd other than "natural", or Items 23a or 28a-f ahov event, the Medical Exameter must be notified at	by F	3 Widowed 4 Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2ĂNo	Specify:		Specify: B	IDAN
5	"natural",	ted	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup	pation	. 16	ib. Kind of Business/Ind	dustry
Ž	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	•	ing		
V	filed withir I Hygiene. other than		12 HGRADE		5	UPERV			BALTO, CITYL	tIGHLUAY DEP
2	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	,	
Ž	should by the marked marked marked	2	RAYMONO  19a. Info ant's Name/Relationship (Typ		UILLI		MARI		City or Town, State, Zip	LLIAMS Codel
2	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		CAPOLUA WILLIAM	e (II) IFF	1/22	12/1/2		-	THORE, ML	500
ı,	Heal	1	20a. Method of Disposition		b. Place of Dispo	sition (Name of	/		c. Location - City or To	
5			1 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other pla	. 1	12-14 6	WINGSMI	in- MO
	permit. Page Department of Important: If Iny injury or Ince.		21. Signature of Funeral Service License		22	. Name and Addre	ess of Facility BA	20010	R. FUNER.	
Õ	Depa Impo any i		Lietuch N	1. Willia	mo	9175K	FULTO	NAVE	BALTO, M.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	eath. Do not ent	er the mode of dyir				Approximate Interval Between
	Physician	fil.	Immediate Cause (Finaf disease or condition	Atheroscle	notri c	circliou	sculard	ice ase	4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con						
	Ladimiler	<u></u>	Sequentially list conditions, b.	Due to (or as a con	saguence of):					
_	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 10 (01 43 4 001)	sequence or,					
,	execun and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a con-	sequence of):					
00	icate be executed physician and s the burial-transit		d.							
0	ntifica ng ph as th	Medical	IE EEMALE.							
200	ith cer tendir rr use	an/h	230. Was decedent program	c. If yes, outcome of pre		Ectopic pregnancy	v		23d. Date of deliver	
	e dea the at hed fo	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time i 9□ Unknown	of death 5	Other (specify)			Month	Day Year
Ċ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions cont	ributing to death but not	resulting in the ur	aderlying cause gry	en in Part I	23e Did tohac	co use contribute to the	e cause of death?
coras,	signe d be	d by			,	radiny mig daddo gir	of the case of			abiy 4 Dunknown
5	v requ	iete						24a. Was an		
ב ב	The law ate has page 2 s	Completed						autopsy performe	prior to com	osy findings available npletion of cause of
N Kal		e C	25. Was case referred to medical				26 Place of Death	1 Yes 2 (Check only one)	No 1 Yes	2 No
	Physician: r this certifica ral director, i	0 B	examiner?	spital:	ER/Outpatien	t 3 DOA Oth			e 6 ther (Specify)	At scene
5	ng Ph ter th	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe how		
200	eath. or: Af	atic	2 Accident investigation				Yes 2 □ No			
Ž	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - A building, etc. (Sp.	it home, farm, stre ecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
_	pital		29a. Certifier 1 Certifying Physi	cien: To the best of my	knowledge death	occurred at the time	me date and place	and due to the cour	co(a) and manner on sta	at a d
	e Hos 24 ho e Fun letely	edicai	(Check only 2 Medical Examin	er: On the basis of exame and manner stated.	ination and/or inv	restigation, in my o	ppinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Month, D	Day, Year)
•	N	ı,	Insto B the	inhere L	60	O.C.M	I.E.	Fe	ebruary 7,	2004
	6		30. Name and address of person who con	and the same of th	Item 23a) (Type,	Print)			A	11/28
			Tasha Z Green		111	Penn Si	reer, Bel	nmore, 1	Tanyland	21201
	Sta	te	31. Date filed (Month, Day, Year)	22: Registrar's Si	gnature					

State Registrar

FEB 1 1 2004 DHMH 17 Rev 1/2001

22: Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** Elizabeth Theresa Wilcox 9, February 2004 12:00 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months 1 M 2 XF 046-30-2639 Yrs. June 8, 1940 63 Connecticut Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f sho iner must be notified at 1 ☐ Yes 2 및 No MD Belcamp Funeral Director Harford 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1400 D. Goldenrod Court 21017 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be Health and Mental em 27 is marked o Joseph (NMN) Urbanowski Mary (NMN) Klezos 19a. Informent's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Harold Louis Wilcox, JR. 1400 D. Goldenrod Court, Belcamp, MD 21017 mportant: If Item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery Assoc. 2/13/04 Macungie, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Mark 1317 Cokesbury Road, Abingdon, Maryland 21009 polications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) attending I 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed director, page 2 should this certificate has 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ٩ 1 Yes 2 No funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: Division After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) edicai 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 437 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFR 1 1

DHMH 16 Rev 6/95

6

FEBRUARY

WILCOX

ELIZABETH

ICIA WRO.	ĽĿľ	State of Maryland / Department	artment of Health and M		_/11111	04065
_		1. Decedent's Name (First, Middle, Last)	3/12/04eg	2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		Patricia Carol Wroten		February	06, 2004	12:06 P <sup>M</sup>
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
C	-	905 Petinot Place  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  5. The security Number of Num	Stevensville  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Queen Ann	C'S place (State or Foreign ptry)
Funeral Director		Z/3-62-0580 10 M 2 F 51 Yrs.	Months Days Hours Min.	June 6, 1	.952 Mar	yland
pu .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	cation		1	0d. Inside City Limits
Marylan f ehow	ō	Maryland Queen Annes Stevensv				1 ☐ Yes 2 🛣 No
with the Page or 286-	Director	10e. Street and Number 905 Pettinot Place	10f. Zip Code 21666	10g.	Citizen of What Cour	ntry?
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. A chert than "natural; or items 23a or 28e-f ehow do other than "natural; or items 23a or 28e-f ehow event, the Madical Evaluate must be multiped at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Mas Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto     □ Yes 2  No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
P hour		15 Decedent's Education 16a, Dece	dent's Usual Occupation	16b	. Kind of Business/In	dustry
Nedia Nedia	piet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing		
ed with ygiene ser that	Completed	12 Blue	Print worker		Light Ra	<b>i</b> 1
S E D	To Be	17. Father's Name (First, Middle, Last) George W. Schultz		e <i>(First, Middle, Maid</i> D <b>i</b> ckens	den Sumame)	
ic, intal yid	ř		ng Address (Street and Number or Rur			Code)
1 and 2 Heelth Heelth tem 27		Treena Clampitt, daughter 1002  20a. Method of Disposition 20b. Place of Dispo	Grovehill Rd. An		Location - City or To	own. State
permit. Pages 1 and 2 Department of Heelth a Importent: If item 27 to eny injury or other tre		1 XBurial 2 Cremation 3 Removal from State	rk Cemetery 02-1		ltimore,	
permit. Departm Importe eny inju	. 19	21. Signature of Euneral Service Licensee	Ambrose Funeral Ho	ome, Inc.		
a acta	V 12	23a, Part1. Enter the disease, or complications that caused the death. Do not ent	1328 Sulphur Spri		butus, MD	21227 Approximate
Fnysician		Immediate Cause (Final disease or condition resulting in death)  Drowning  a.  Drowning	of the mode of dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):				
led list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
be executed sicien and burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):				
ot of ot	dicai	d				
death certifical	Physician/Med		Ectopic pregnancy		23d. Date of delive	ery Day Year
the de	hysic	1 Se 2 No 9 Unknown 9 Unknown	Other (specify)			
The Coulds, F.C. BOX 80100,  The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	2 No 3 Prot	ne cause of death?
ding Physicien: The law requir h. After this certificate has been si funeral director, page 2 should	Completed			24a. Was an autopsy performed	prior to co death?	ppsy findings available mpletion of cause of
icien: T	a	25. Was case referred to medical	26. Place of Deat	1 ☐Yes 2 ☐ h (Check only one)	140 1163	20140
g Physicien: er this certifica	n: To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 1  Month, Day Year) 1  Natural 5 Pending		ome 5 Residence 28d. Describe how in		) SCENE
SICIT tending leath. tor: Afte the fune	atio	2 Accident investigation 2/6/04	45a 1 ☐ Yes 2 1 No	subject drow	ned in bath	tub
or Attenditer death lirector:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
pitel o	Ce	home  29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat		205 Petinot 1		
To the Hospitel or Attending within 24 hours after death. To the Funerel Director After completely filled in by the fune	edical	(Check only one)  2 Medical Exeminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		> Wayne mercule hu	O.C.M.E.	F	ebruary 07	7, 2004
(4)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)  1 Penn Street, Bal	timore M	arvland 21	1201
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		споте, М	шулам 2.	LZUI
Registr	ar	FFR 1 1 2004 Denie	4 Aproved			

			For State Registrar	State of M	aryland		artmen			and M		giene Reg. No.	200	+ 0	-	066
	Physici	an	1. Decedent's Name (First, Middle, Las GERALDINE	WEAVER							2. Date of De Month 2/9/	$04^{^{Day}}$	Year		me of 0	Death A M
À	/Medic Examin		4a. Fecility Name (If not institution, given ROCK GLEN NUR)	e street and number)					Location of		7 - 7	4c.	County of Dee			
	Funeral Director		220 12 0211	ex	e (In yrs. la 80	est birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 11/23	$\frac{1}{2}^{\text{th}}$	9. Bir	thplece (Sountry)	tate or	Foreign
	nyland how	_	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo								10d. Insi		y Limits
	the Ma	Director	MD. n/a			BAL	TIMO					10a. Citiz	zen of What C	1	103	242110
	3e or		810 KEVIN	RD.			101. 210		229				USA	,		
36	72 hours after deeth with the Maryland Insture!, or Items 23e or 28e-f ehow Ideal Examinar must be notilied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:			Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ocify Yes or No Ricen, etc.)		14. Race - Am Black, Whi Specify:			
Maryland 21215-0036		Completed	15. Decedent's Ec (Specify only highest grade Elementary/Secondary (0-12)	ducation ide completed) College (1-4or	5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	rk done d	uring most	t of worki	ng	18b. Kir	nd of Business	/Industry		
/land 2	should be filed within and Mental Hygiene. I merked other than umatic event, the Mental Control of the Mental	To Be Co	17. Father's Name (First, Middle, Last)							IAI	(First, Middle	. SI	HTIM			
	nd 2 shoulth and		19a. Informant's Name/Relationship ( DELORES MARSHA								Richmon			Zip Code)		
Baltimore,	Pages 1 and the Heat of Heat of Heat It is the Heat Iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification 2)		L Ce	ace of Dispo emetery, cren	esition (Name natory or o estern (	ther place			02/13/04	20c. Lo	cation - City or Baltimore			
Balt	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Licer C.A.ESTEP	astey	0	22	130	derderes O E	BROS	· PE	JNERAL BALT	o.HO	ME.P21	217		
	Physician		23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each line.  a. Ren  Due to (or as	ine.			e of dying	g, such as	cardiac o	r respiratory a	rrest,		Interv	ximate al Betw and D	veen
9	/Medical Examiner		resulting in death)	b. Due to for as												
The state of the s	d ansit	Examiner	Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or ás	a consequ	ence of):										
8760,	ate be executed thysicien and the burial-transit	ical	resulting in death) Last	Due to (or as	a consequ	ence of):										
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy bage? should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					2	3d. Date of de Month	olivery Day	Y	'ear
۵.	quires that the signed by ald be detacted	by	Part II. Other significant conditions of	_		-		-	n in Part I.				se contribute t			- 1
Vital Records,		Completed	"								24a. Was auto perfo 1 🗆 Yes		24b. Were a prior to death?	completio	n of ca	
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes  No	Hospital:	ent 2 🗆 I	ER/Outpatier	at 3□ 00	Othe			( <i>Check only c</i> me 5 ☐ Resi		Contract (So	acifu)		
ion of	Attending Physic death.  ector: After this by the funeral di	$\vdash$	27. Manner of Death  12. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work	at		28d. Describe			scily)		
Division	하 # 품 드	Certification;	3 Suicide 6 Could not b 4 Homicide determined	200. Flace of ill	jury - At ho tc. (Specify	me, farm, str	reet, factory	, office			28f. Location ( City or To			lural Route	Numb	⊃e <i>r</i> ,
	Hospitel	edical (		ysician: To the best ninar: On the basis of and manner st	of examinat										use(s)	
	To the within 2 To the comple	Me	29b. Signature and thus of certifier	7//				License		/			e signed (Mon		ar)	
,	n		30. Name and address of person who	completed cause of	death (Item	23a) (Type,		145	3386	,		2	11 104			
	زد			Hours of				Pl	cep,	Bu	1 himory	Ni	> 2/2	217		
	Sta Registi		31. Date filed (Month Day Year) & U	THE REGIS	ass Signal	nte	See J									

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Ze 04 ende 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Golden Age Guest Home MILLA 8. Date of Birth (Morth, Day, Year) April 7, 1921 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Min Days Hours 1 M 2 T F 82 Yrs 213-16-4926 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 √ No Carrol1 Sykesville MI 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 6765 Marvin Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LPN Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Barnard Phoebe Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. ada E. Patterson (Daughter) 6765 Marvin Ave., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens 2/10/04 Havre De Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1. Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Unursing Home 5 - Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

**Physician** /Medical Examiner To the Hospital or Attending Physician: The lew requires thet the deeth certificate be executed Division of Vital Records, P.O. Box 68760, certificete deeth. within 24 hours completely

ettending physician end I for use es the bunel-trensit ete hes been signed by the page 2 should be deteched director. eral Director: After this filled in by the funeral di

**Physician** 

/Medical

Examiner

Funeral Director

<u>م</u>

Completed

Be

ပ

Physician/Medical Examiner

þ

Completed

Be

2

Certification:

edlcai

29a. Certifier

29b. Signature

(Check only

**Funeral** 

Director

State Registrar 31. Date filed (Month, Dey, Year) 2004 1

ATRICK

alle

nd title of certifier

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

wo

URNUS

1 Y Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20806

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** February 9. 2004 1701 Hursel Holt White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days MOXM 2□ F May 18, 1921 Director 530-05-6685 82 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 ie marked other than "naturel", or Iteme 23e or 28e-f ehov other traumatic event, in Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Harford Abinadon Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3700 Deer Chase Court 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ty⊡Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify 2 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 7 and Mentet Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator 12 Ornamental Iron Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Holt (nmn) White Fannie May Shreaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 Deer Chase Ct., Abingdon, Maryland 21009

Oate 20c. Location - City or Town, State t of Heelth Mildred R. White / Wife Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important of important: if it eny injury or or ones. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

• 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp! 2-12-04 Towson, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 comes Pail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use es the buriel-trensit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EF/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours e 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Func

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FFR 1 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1041

36336

32. Registrar's Signature

ND

29c. License numbe.

29d. Date signed (Month, Day, Year)

Xberdeer

			ricase	State of Marylan					_		ibic.	
		•	For State Registrar	otato or marytan		rtificate				Reg. No.	04	04069
	Physici		1. Decedent's Name (First, Middle, Las BESSIE	NORMA	- W	000	EN	1	2. Date of De Month FEBRY	Day	Zooy	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give Subacute AT Not			4b. City, T	Town, or L	Location of De	ath IN	4c. Count	y ol Deeth	IORE
ž.	Funeral Director			G	last birthday) 88 Yrs.	If Under 1 Months	1 Year Days	If Under 24 H Hours M		4,1915	9. Birth	olece (State or Foreign ntry)
	land		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e-f sh	ctor	MD ANNE A	RUNDEL	ANNA	POLIS						1 Tes 2 No
	with th	Funeral Director	10e. Street and Number	VΓ		10f. Zip (		01401	:	10g. Citizen of		
	ns 23	erai	1515 CIRCLE DRI	12. Was Decedent Ever in U.	S. 13.	Was Decede		21401 panic Origin?	(Specify Yes or No erto Rican, etc.)	)- 14. Ra	ce - Ameri	
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or items 23e or 28e-f show he Modical Exercitor mast be multified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 N No If Yes, Give Year or Dates;	i	lf Yes, specr 1 ☐ Yes 2		, Mexican, Pu Specify:	erto Rican, etc.)	Speci	ick, White, fy:	etc. WHITE
15-0	natur	leted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual kind of work DO NOT use	k done du	tion uring most of v	vorking	16b. Kind of 6	Business/In	dustry
212	yethir piene. r than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSE		9 79(1190)			OWN HO	ME	
Maryland 2	ges 1 end 2 should be filed within it of Health and Mental Hygiene. If Item 27 is marked other than or other treumatic event, the Meres of the Meres	To Be C	17. Father's Name (First, Middle, Last) FRANK		KERSC	HMAN		18. Mother's N LENA	lame (First, Middle	, Maiden Suma		ENSPUN
lary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (	1-0					Rural Route Numb			
	1 end 2 Health tem 27 i		STANLEY HOLZMAN  20a, Method of Disposition	20b. P	lace of Dispo	sition (Name	e of		Γ - PASAD Date	ENA, MD 20c. Location		
MO	Pages lent of nt: If it iry or o		1 ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State	emetery, crei RKMEN				9/2004	DUNDA	LK. M	ID
Baltimore,	permit. Pages 1 end Department of Health Importent: If Item 27 any injury or other tr 900.		21. Signature of Funeral Service Licer		22	2. Name and	Address	of Facility	SOL LEVIN N ROAD -	SON & B	ROS.,	INC.
	Physician		23a. Part1. Enter the dispase, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line.	h. Do not ent	er the mode			liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	- ( - (						
	<b>A</b>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq	uence of):							
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):							
1760,	ite be e iysiciar ne burii	cai		d								
89 x	entifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pregna								
O. Box	The law requires that the death certifical ate has been signed by the attending phypage 2 should be delached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of d	tdeath 3□	Ectopic pre Other (spe					ate of deliv	ery Day Year
Ω_	uires that the de signed by the a Id be detached f	by Ph	Part II. Other sonificant conditions of	ontributing to death but not res	ulting in the u	nderlyi <i>n</i> g ca	use giver	n in Part I.	23e. Did	tobacco use cor	tribute to t	he cause of death?
ord	w require been si should t	eted								Yes 2 □ No	3 ☐ Prot	
Division of Vital Records,	sician: The law certificate has t irector, page 2 s	Completed							24e. Was auto perfo 1 Yes		prior to co death?	ppsy findings available impletion of cause of
Vita	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:			Other		Death (Check only			
οt	g Phys ter this neral di	n: To	1 Yes 2 No  27. Manner of Ceath	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		A Bc. Injury i Work?	at ursing	g Home 5 ☐ Resi 28d. Describe	dence 6 ∐Ot how injury occu		ý)
sior	uttending P death. ctor: After / the funer	catio	13 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2 No	001			10 11 11 -1
Dİ	tel or Al	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, iarm, str y)	eet, factory,	, office			wn, State)	ber or Hun	al Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai		ysician: To the best of my kno niner: On the basis of examina and manner stated.								
	To the within to the comp	Ň	29b. Signature and title of certifier	· Lan	1	29c.	License /	37	333	29d. Date sign FEBRY I	ARY	Day, Year) 8, 2004
	3		30. Name and address of person who	completed cause of death (Item	п 23а) (Туре,	Print)		40.	333			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Courses 1	0					
100			FFR 1 1 2	UU4 - Bull Change.	14	No. of Street, or other Parks						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 04070 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year YOST 02 10:20 SM WILLIAM 06 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NEDICAL CENTER BALTIMORE BAYVIEW BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. Mar. 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** tXIM 2□ F 213-09-2543 91 Director 1912 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location wode 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: if item 23s or 28s-1 show important: if item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event, its Medical Exacts are mast be notified as Maryland Baltimore Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 9102 Abigail Avenue United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 € No Specify: White Specify 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Yost Annia A. Gatha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Marston - Niece 2022 Codd Avenue Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2/10/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDS **Physician** HOURS /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2. No furneral director 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No ٩ 1 ×Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After Certification; To the Hospital or Attending 5 Pending investigation 1 Natural Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident y the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 02/06/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER CAPIL PARAKK BAYVIE W 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 04 OMonth **Physician** 11:40 % Harriet Aquilino /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles LaPlata Civista Medical Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 79 Yrs. 8. Date of Birth Sept. 20, 9. Birthplece (State or Foreign 1924) MA. 5. Social Security Number 6. Sex **Funeral** 1 M 30 577**-**30-9354 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ral', or Itema 23a or 28a-f show Examiner trust be notified at 1 ☐ Yes 2 No Pomfret MD Charles Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20675 USA 4195 Columbia Park Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Cosmetic is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Katherine Higgens McNeil William M. McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau William Pemberton/Step-son 4195 Columbia Park Rd. Pomfret, MD 20675 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols F.H. 1/31/04 Charlotte Hall, M ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ARTHART ECHOLS FUNERAL HOME, P.A. MOO945 P.O. Box 567 LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMPHYSEMA **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknowh 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) o 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1⊠Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30/2004 D-5228930. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10 St. Patricks Drive Suite 404 Waldorf, MD 20603 Mathur, Nalin, 32. Resistrar's Signature 31. Date filed (Month. Day, Year) FEB 0 2 2004 State doeses Registrar

		1	For State Registrar	State of Mary			of Health ar of Death		giene Reg. No. 2	2001	+ 04072	
	ysicia Viedica	ai	1. Decedent's Name (First, Middle, Last)	HC5			Janua	January 24 2004 00,004				
	Examin		4a. Facility Name (If not institution, give s.  HOWAND OL  5. Social Security Number 6. Sex.	ney Gen	eral Hosp yrs. last birthday	) If Under 1	(Olw Year If Under 2	mbed Hrs. 8. Date of Birti		100	thplace (State or Foreign	
Dire	eral			M 2□F 8	V	Months D	Days Hours	OCT 4,	1922		IGARY	
death with the Maryland me 23a or 28a-f ehow	Tie Cell	tor	10a. State 10b. County  MARYLAND HOWARD	100	CLARKS						10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
th the	100 a	Directo	10e. Street and Number			10f. Zip Co			10g. Citizen		10.	
aih wi	4		7120 CHILTON COURT			21029				UNITED STATES		
after or		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Amed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 □  Yes Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
1215-003 within 72 hours ene. then "neturel",	event, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)			6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
21 ad wit ygjene er th	크	Sol	12			DENTAL TECHNICIAN				DENTISTRY		
Maryland 21 d 2 should be filed wi th and Mental Hygien 77 is marked other th	> ·	To Be	17. Father's Name (First, Middle, Last)  IGNAC GOLDSTEIN			18. Mother's Name (First, Middle  SARTNA R  ailing Address (Street and Number or Rural Route Numb			OSENBLUH			
Var 12 sh nand	me		19a. Informant's Name/Relationship (Typ	ne, Print)								
E, N 1 and Health em 27	thert	-	GEORGE ACS, SON  20a. Method of Disposition	21	0b. Place of Disp	osition (Name	of !	CLARKSVILI Date			Town, State	
Pages Pages nent of nut: If it	5/2		1 \( \overline{X}\)Burial 2 \( \overline{Cremation} \) 3 \( \overline{Re}\) 4 \( \overline{Donation} \) 5 \( \overline{Other (Specify)} \)	emoval from State	•	ematory or othe		s 1/25/04	OT NEV	MAD	VI AND	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men important: If item 27 is marke	any injur.		21. Signature of Fundral Service License		į	22. Name and DANZANS	Address of Facility  KY-GOLDB	ERG MEMORIA	AL CHA	PELS,		
Physic /Med			23a Part1. Enter the disease, or complice shock, or heaft failure. List only on Immediate Cause (Pinal disease or condition resulting in death)	e cause on each line.					rest,		Approximate Interval Between Onset and Death	
that the death certificate be executed that the attending physician and detached for use as the burial-transit	ne burial-transit	dical Examiner	d									
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certifical Natin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph	ched for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day Year				
'dS, P juires that	ld be deta	d by Pt	Part II. Other significant conditions contributing to death but not resulting in the under Dup versus terrorule of the				nderlying cause given in Part I. 23e. Did			tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown		
Recol	irector, page 2 should I	complete	Lep verom thrombos hyperoagulable stall alcertil colitis			24a. Wa aut per 1 □ Yes			prior to completion of cause of death?			
/ita	ctor.	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
Division of V  or Attending Physic after death. Director: After this of	9	၉	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Hospital: 14 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  M 1 Yes 2 No							ocify)	
DIVISI	d in by the	Certification:		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street an City or Town, State						nd Number or Rural Route Number, le)		
o the Hospite whin 24 hours	oletaly fille	Medicai C	29a. Certifier (Check only one)  Certifying Physical Certifying Physical Exemination (Check only one)	ician: To the best of mer: On the basis of exa and manner stated.	y knowledge, dea amination and/or	ath occurred at investigation, in	the time, date and n my opinion, death	place, and due to the occurred at the time,	cause(s) an date and pla	d manner a	s stated. e to the cause(s)	
	com	ž	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32 Registrar's Signature  33. Registrar's Signature  34. Registrar's Signature  34. Registrar's Signature  35. Registrar's Signature  36. Registrar's Signature  37. Registrar's Signature  38. Registrar's Signature  39. Registrar's Signature  39. Registrar's Signature  30. Registrar's Signature  31. Registrar's Signature							in, Day, Year) 14 Th 2004		
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Sell L	n. Cla	rusnill	en	10 0	71029	
R	Sta egistra		31. Date filed (Month, Day, Year) JAN 28 2004	32 Registrar's	Signature	ppour	Kal					

	-	For State Registrar	State of	Marylan		artment tificate				R	eg. No.	004	04073
Physicia	n	1. Decedent's Name (First, Middle Sang Chul	e, Last) Ahn							Date of Dea Month nuary	Day	004 Year	3. Time of Death 7:20 P M
/Medica Examine		4a. Facility Name (If not institution		ber)		4b. City, T	own, or	Location of (		, , , , , , , , , , , , , , , , , , ,		ty of Death	
		Shady Grove Adv	ventist Ho	spital				ville				Montgo	•
Funeral Director		5. Social Security Number 225-96-8652	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day 1y 28	1937	9. Birthi Cou Ko1	place (State or Foreign ntry) rea
and	-	Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
a-f aho	ctor	Maryland Mon	tgomery		Roc	kvill	e						1 ☐ Yes 2 XNo
with the	Funeral Director	10e. Street and Number 13103 Arctic	Avanua			10f. Zip (	208	53			Og. Citizen o		ntry?
ns 23	eral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decede			n? (Specify	/ Yes or No- an, etc.)		ace - Amen	
iiit. Pages I and 2 should be filed within 72 hours after death with the Maryland artinent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show ontant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury other traumatic avant, items Madical Exactifies must be from a significant.	by Fun	1 ☐ Never Married 2 ☒️ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	2 [X] No ∍		f Yes, specr 1 ☐ Yes 2		Specify:	Puerto Ric	an, etc.)	1	ack, White,	
nin 72 hoi n *naturi	Completed by	15. Deceder (Specify only higher Elementary/Secondary (0-12)	it's Education st grade completed)	4or 5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupa k done di e retired)	tion uring most o	of working		16b. Kind of		·
d within giene. er than	E O	12			upł	olste							nanufactur
12 should be filed within hand Mental Hygiene hand Mental Hygiene ? 7 ie marked other than "Iraumatic avant, tra Men	Be	17. Father's Name (First, Middle, Yoon Shik Ah								irst, Middle, l Kim	Maiden Suma	ame)	
hould ad Mer mark matic	ဋ	19a, Informant's Name/Relations			19b. Mailir	ng Address	(Street a				r, City or Tow	n, State, Zij	o Code)
nd 2 salth ar 27 ia		Joan M. Ahn /	daughter		6805	Rose	mont	Dr.,	McLe	an, V	irginia	a 2210	01
permit. Pages 1 and 2 Department of Health a Important: If itsm 27 is any injury other tra		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from S		Place of Dispo cemetery, crea				Date		20c. Location		
tment tant: tant:		* 4 □Donation 5 □Other (S	Specify)	Ft.									Maryland
Departiment of the service of the se		21. Signature of Funeral Service	Disensee	Sol(	9						ldi Fur		ноте g, MD 2090
Physician	1	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	complications that conty one cause on e	use I the deal									Approximate Interval Between Onset and Death
ysicis	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a consequence as	UMAN UMAN	ia							2 days
nat the death certifica d by the attending ph letached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pre Other (spe						Pate of deliving	rery Day Year
w requires that the been signed by the should be detached	d by PI	Part II. Other significant conditions End 54	_		ulting in the u		iuse give	n in Part I.		23e. Did to			the cause of death? bably 4 □Unknown
has has	Completed by		J							24a. Was a autop: perfor	sy	o. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital: 🔏				Othe		of Death (C	heck only o	ne)		
Phys this	-T	1 ☐ Yes 2 No 27, Manner of Death	V		ER/Outpatier 28b. Time o		^	4 🗀 14013	-		ence 6 00 ow injury occi	. ,	fy)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	1 Alatural 5 Pendi 2 Accident invest 3 Suicide 6 Could	not be 380 Place	of Injury h, Day Year) of Injury - At h	Injury	М		? ′es 2 □ No	281			nber or Rur	al Route Number,
To the Hospital or Attending Phywithin 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	Certil	4  Homicide determ	nined buildir	ig, etc. (Speci	<sup>(y</sup> )			e date and	place and	City or Tow		manner as	stated
ne Hos na Funa sletely f	Medical	29a. Certifier 1 Certifyi (Check only 2 Medical one)	Examiner: On the ba and mann	sis of examina	ation and/or in	vestigation,	in my op	inion, death	occurred	at the time, o	late and place	e, and due t	to the cause(s)
To the within To the comp	ž	29b. Signature and title of certific	er /					number			29d. Date sign		
(		1			M		U S	6656	2		) anva	ry 2	1, 2004
		30. Name and address of person	who completed caus			Print)	Me	di cal	Cen	H- (	rive	Kor	1, 2004 kvill, MO
1		31. Date filed (Month, Day, Year		gistrar's Signa		- 1	,,,,		-( '(			(	L. VIII

State of Maryland / Department of Health and Mental Hygiene 2004 04.076 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2:30 a M Henry William Altheide January 28, 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 15505 Prince Frederick Way Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min. 1⊠M 2□ F Yrs. 577-32-8047 76 January 15, 1928 Illinois Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State e filed within 72 hours after death with the Marylan at Pygiene other than "naturat", or Itema 23a or 28a-f ehow other than "naturat", or Itema 23a or 28a-f ehow vent, The Medical Exam an mark a notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 15505 Prince Frederick Way by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Cartographer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi. I Health and Mental H Item 27 is marked off Be Henry Theodore Altheide Anna Lloyd ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health 15505 Prince Frederick Way, Lorraine Elizabeth Altheide Silver Spring, MD 20906 ant of He. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ott January 30 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 2004 \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 ach Approximate Interval Between Onset and Death 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocardial Infarction **Physician** Immediate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Heart Disease l vear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Se attending f IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed' 1 ☐ Yes 2 🖾 No certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours To the Funerel 150 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of certifier D24543 January 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi M.D. 3305 N. Leisure World Blvd., Silver Spring, MD 20906 31. Date filed (Month, Day, Year) JAN 2 9 32. Registrar's Signature State outes 2004 Sper Registrar

			1 - For Stete Registrar	State of Marylan		artment of Health		ental Hygien	2001.	04075
	Physic /Medi	cal	Decedent's Name (First, Middle, Last)     Nokisha Y. But      Aa. Facility Name (If not institution, give seems)	ler		4b. City, Town, or Location	J	anuary	16 2004	3. Time of Death 9:12 A
	Examir	ier	Prince George 5. Social Security Number 6. Security	S Hospital	V	Chev	erly der 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	Prince  9. Birthpla Countr	George's ace (State or Foreign
響か	Director		577-92-9537 Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	ocation	<u> </u>	lay 31, 19		yland d. Inside City Limits
	with the Ma la or 28a-f	Directo	Maryland Prince 10e. Street and Number 702 Birchleaf	George's		Capitol He		10g. C	Citizen of What Countr	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avent, the Medical Example and the colling and once.	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No 1f Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Speci ican, Puerto Ri	ify Yes or No- can, etc.)	United Sta 14. Race - American Black, White, et Specify: Bla	n Indian,
Maryland 21215-0036	within 72 ho ane. than "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during in DO NOT use retired)		16b.	Kind of Business/Indu	ıstry
land 2	uld be filed a Mental Hygie rked other i tic avent, the	To Be Co	12th 17. Father's Name (First, Middle, Last) Tony Lev	vert Butler		Handicar 18. Mo		First, Middle, Maide Belinda	,	
e, Mary	1 and 2 sho Health and P om 27 is ma thar trauma		19a. Informant's Name/Relationship (Ty, Belinda Cook-Vann  20a. Method of Disposition	nall/Mother	34	ng Address (Street and Num 402 - 55th Avstrion (Name of		03, Hyatt		D 20784
Baltimore,	mit. Pages partment of cortant: If its injury or o		1 □ Surial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	emoval from State G16	emetery, crer enwood	natory or other place)	1/24/	2004	Wash., D.	
n n	permi Depa Impo any i		23a. Part . Enter the disease, or complishook, or heart failure. List only on	e cause on each line.	1. Do not ent	4001 Benning er the mode of dying, such	Rd., N	.E. Wash.	, DC 20019	9 Approximate nterval Between Onset and Death
8760,	death certificate be executed  e attending physician and do for use as the burial-fransit	dical Examiner	Immediate Juse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	12 av b	11.	tens	ion		
.O. Box 6	at the death certific by the attending p tached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month D	/ Vay Year
Records, P.	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resu	ilting in the u	nderlying cause given in Pa	rt I.	23e. Did tobacco	use contribute to the	
		<b>Completed</b>	25. Was case referred to medical					24a. Was an autopsy performed?	prior to comp death?	y findings available pletion of cause of
5	ysician: is certific director,	o Be	examiner?	ospital: 1X Inpatient 2□ I	ER/Outpatien	0		Check only one)	6 ☐Other (Specify)	
Division of Vital	ng Ph ter th neral	-	27. Manner of Death 1, Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? M 1 Yes 2	280	d. Describe how inju		
DIVIS	Hospital or Attendii 4 hours after death. Funeral Diractor: A tely filled in by the fu	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	)			City or Town, Stat		
	Hos 24 hc Fun etely i	Medical	29a. Certifier (Check only one)  Certifying Phys  Certifying Phys  Certifying Phys  Check only one)	ician: To the best of my know ter: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my opinion, d	and place, and leath occurred	due to the cause(s at the time, date an	<ul> <li>and manner as stated place, and due to the</li> </ul>	ed. ne cause(s)
	To the Hospital (within 24 hours at to the Funeral D	Me	29b. Signature and title of certain	lun		29c. License numbe	5		ate signed (Month, Da	*
ia —			30. Name and address of person who con	3001 Hase,	THL .	Print) DRIVE	CHEVER	LY, MD	20785	
	Sta Registr		JAN 2 7 2004	32. Registrar's Signat	ure			,		

					State	of Mary	rland / I		irtment of tificate of			lental Hy	giene 2 (	004	040	176
			1. Decedent's Name (First	, Middle, L	ast)							2. Date of De	ath		3. Time of E	Death
	Physicia		James	۸ 1	bert		Brenn	ລກ				Month VA-> J4	Day	Year 2004	7:3	5pm
1	/Medic Examin		4a Facility Name (If not in			ımber)	DI CIIII	an		4b. City, To	wn, or Lo	cation of Deal	1	ty of Death		
Ĵ.	LAGIIIII	C1	Prince Geor	TAC C	Ionoral	Hospi	tal			Cheve	er1v			ice Ge	orges	
	Funeral		5. Social Security Number		Sex		yrs. last bir	thday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Bi	th	9. Birthp	ace (State or	Foreign
	Director		283-01-1531		1 <b>∑</b> M 2□ F		89	Yrs.	Months Days	Hours	Min.	(Month, Da	$9, \frac{Y_{\theta ar}}{1914}$	Coun	try)	
			Usual Residence of Deced	ient			0,7					200.	, , , , ,			
	ylan		10a. State 10b.	County		10	c. City, Tow	n or Loc	cation					10	Od. Inside City	
	Mar Mar	호	Maryland Pr	ince	Georges	;   E	Bowie								1XX Yes 2	2□No
	r 28	Director	10e. Street and Number						10f. Zip Code				10g. Citizen of	What Coun	iry?	
	3a c	무	4725 Ramsgat	e Lar	ıe				2071	.5			U.S.A	١.		
	d within 72 hours after death with the Maryland yiene. r than "netural", or terms 23a or 28a-f show the Medical Evaciner must be notified at	Funerai	11. Marital Status		12. Was Dec	edent Ever	in U.S.	13. W	Vas Decedent of	Hispanic Ori	gin? (Spe	cify Yes or No	)- 14. Ra	ce - America		
0	r ite	ᆵ	1 ☐ Never Married 2	☐ Married	Armed Fe 1 ☐ Yes If Yes, Gi				Yes, specify Cul		i, Puerto	Rican, etc.)		ack, White,		
8	urs a	þ	3K Widowed 4□Di	vorced	If Yes, Gi Year or E	ive 11 Dates:		1	☐ Yes 21 No	Specify:			Spec	ity: Whi	te	
Ŏ	2 ho	Completed by	15. De	cedent's E	ducation		16a.	Decede	ent's Usual Occu	pation			16b. Kind of I	Business/Ind	ustry	
2	c * 6	음	(Specify only Elementary/Secondary (		ade completed) College (		-	(Give k	ent's Usual Occu kind of work done O NOT use retire	ed) ed)	of worki	ng	U.S.			
7	filed within Hygiene. Ither than "r	E	12	0-12)	College (	1-401 5+)	Ona	1 i t :	y Contro	1 Ins	nect	or	Govern	nment		
g	ë ₹ <b>6</b> £	Bec	17. Father's Name (First, M	Aiddle, Las	t)		Quu		J 001121 C				Maiden Suma			
<u>a</u>	D = D =	0	Thomas			Brenn	nan			Ali	ce		Cor	nors		
ar.	d 2 should be the and Menta 7 is marked traumatic ex	┺┤	19a. Informant's Name/Re	lationship	(Type, Print)	DI CIII		. Mailing	g Address (Stree	1		I Route Numb	er. City or Tow	n. State. Zip	Code)	
Ĕ	47 5 6 2 5 6 7 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5		John T. Bren	nan/	Son				Ramsgate				iaryland		'	
ē,	f Health item 27 i	ŀ	20a. Method of Disposition		5011	2	0b. Place of	Dispos	ition (Name of		_	Date	20c. Location		vn. State	
ē			1X Burial 2 ☐ Crem	ation 3 [		State 5	Pacred	y, crem He.	atory or other pla art Cath	nolic	1	/26/04				
₽	permit. Page Department of Important: If any Injury or once.	-	4 Donation 5 Of			- (	Church	I (.e1	meterv		Dob	ant E	Bowie			
Baltimore, Maryland 21215-0020	Depariment Important		21. Signature of Funeral S	ervice Lice	nsee				Name and Addr							
_	0 □ = <b>0</b> 0		allen	hu	de			10	000 Anna	thorrs	Koa	ı, bov	vie, Mar	cyland	2071.	5
			23a. Part1. Enter the diseashock, or heart failure	ase, or con	plications that o	caused the	death. Do r	not ente	r the mode of dy	ing, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betwe	000
	Physician	i												1	Onset and De	eath
	/Medical	1	Immediate Cause (Final disease or condition			Car	م حال	س ( ب	u anom	Cal	(	060			Minut	
	Examiner		resulting in death)		a	Due	to (or as v	ronsenii	uence of):	3	4	211				(~1
		je				COF	20 6	2	ionico ory.	1				1	hours	c
	ficate be executed 3 physician and as the bunal-transit	Examiner	Sequentially list conditions		b		to (or as a d	Onsequ	rence off.	ron						
Ć.	execting and and and and and and and and and and		Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	ė			(	onocqu								
68760,	e be Sicia e bui	edicai	Cause (Disease or injury that initiated events	~	c	Duo	to (or as a c	000000	anan af).							
9			resulting in death) Last			Due	io (oi as a c	onsequi	erice oi).					1		
	ding se a	\$			d								**			
Вох	atter for u	ig														
<u>о</u> .	law requires that the death certit as been signed by the attending 9.2 should be detached for use a	Completed by Physician/M	Part II. Other significant co	onditions	contributing to de	eath but no	t resulting in	the und	derlying cause gi	ven in Part I.		23b. Did	obacco usa co	ontributa to	tha causa of	death?
α.	hat the	₹	Corela	or	Anajt	_						1 🗆	Yas 2□ No	3 Prob	ably 4 □ Ur	nknown
Š	res t	2	0			_	r /					_				
ö	inbe.	ě	Kes	rint	by I	nsul	Ton	cy				24a. Was perfo	an autopsy rmed?	avai	e autopsy find lable prior to	_
O O	as b	<u> </u>			1		25	1						of d	pletion of cau eath?	ise
<u> </u>	The tree h page	Ę !	Con	nan	y Aut	en	4 con Dise	end				10	es 21XNo	1 🗆	Yes 200 No	0
ā	tifica		25. Was case referred to m	iedical						26. Place	of Death	(Check only c	ne)	1		
>	ysici s cer direc	0	examiner? 1 ☐ Yes 2 X No		Hospital: 1	fipatient	2 ☐ ER/Out	tpatient	3□ DOA Oti			E	lence 6 □Ott	ner (Specify)		
Division of Vital Records,	y Ph		27. Manner of Death		28a. Date	of Injury	28b. T	ime of	28c. Inju Wo				now injury occu			
0	th.			Pending nvestigatio		th, Day Yea	ir) ir	njury		nk? ∣Yes 2∐N	lo					
<u>s</u>	Atter dea ctor y the	≌	3 ☐ Suicide 6 ☐ 9	Could not b	e 28e. Place	of Injury -	At home, far	m, stree	et, factory, office		2	8f. Location (5	Street and Numi	ber or Rural	Route Numbe	ər,
á	after Dire		4 ☐ Homicide		buildi	ng, etc. (Sp	ecify)					City or Tov	m, State)			
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 X Ce	rtifyina Ph	vsician: To the	best of my	knowledge	death	occurred at the ti	me, date and	place a	nd due to the	alleg(e) and m	anner as sto	ted	
	Fur etely	20		dical Exar	<b>niner</b> : On the ba	asis of exam	nination and	Vor inve	stigation, in my	ppinion, deat	n occurre	d at the time,	date and place,	and due to t	he cause(s)	
	ithin o the omple	Z -	29b. Signature and title of o	ertifier /					29c. Licens	se number			29d. Date signe	ed (Month. D	ay, Year)	
_	F≯Fŏ			M	1 15				1		C. 1 "		_			511
			^ ^	w	Le T	ign			Do	054	80	1	JANU MD &	my 2	7, 63	7
•			30. Name and address of p		. /	/ 4			rint)	2	1	-1-00	(1)	. 40-		
			MICHAEL 1	-1GA+				DSFI	THE OK		CH	EVEXLY,	MD a	0705		
	State	2	31. Date filed (Month, Day,	9 G	2004 32. R	ec strar's S	ignature	82	Land -							
	Registra		<b>UNI</b>		LUUT	· 中国	1 AT	- 4	B 的作品提及							

		1 - For AMEND#2 per phy. Registrar 1/29/04, AAOO 1				artmer <i>rtificat</i>			ınd M		Reg. No.	2004	0407
Physic /Medi		1. Decedent's Name (First, Middle, Las Anna F. Benick	t)							2. Date of De Month Jan.	21, Day	200 <del>4</del>	3. Time of Death 5:30 p
Exami		4a. Fecility Name (If not institution, give Chesapeake Hospi	ce House				L	inthic	cum	O. Data of Ric	,	Anne Ar	rundel
Funeral Director		5. Social Security Number 214–38–4804 1  Usual Residence of Decedent	ox 7. A □M 2ᡚF	83	last birthday) Yrs.	Months	1 Year Days	Hours	Min.	8. Date of Bir (Month, Da Jul. 27	1, 192	0	hplace (Stete or Foreig untry) PA
Maryland -1 ehow	tor	10a. State 10b. County MD Anne Ar	rundel	10c. Cit	y, Town or Lo		nold						10d. Inside City Limit:
3e or 28e	Funeral Director	10e. Street and Number 1209 Finneans Rur	1			10f. Zij	Code 210	12			10g. Citiz	en of What Co USA	puntry?
be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Exercites must be routiled at	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	? No		Was Dece If Yes, spe 1  Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify:	
i within 72 ho jiene. r than "natur ire Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	life.	dent's Usu kind of wo DO NOT L tory	ork done d se retired	turing most	of working useho	old		of Business	Industry dustries
ould be filed Mental Hygid Marked other Martic event, Il	To Be C	17. Father's Name (First, Middle, Last) Peter J. Kociole	ek							(First, Middle Mary Gr			
nd 2 sh lith and 27 ie m r treum		19a. Informant's Name/Relationship (		er		-				Route Numb		Town, State, 2 21012	Zip Code)
·		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			Place of Disponentery, created H.	matory or	other plac		Jan.	25, 2004		ation - City or oklyn,	
permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licen	aun.		B 4	arran 95 Go	d Addres CO & V. r	Sons itchie	P.A é Hwy	A. Seve	erna l erna l	Park Fi	neral Home D 21146
Physician /Medical		23a. Part1. Enter the disease, or comprock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that cause one cause on each	line.	nphys		de of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner sicien and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a conseq	uensa of):								
death certificate e attending phy id for use as the	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	⊒Ectopic p ⊒ Other (s					2	3d. Date of de Month	ivery Day Year
quires that in signed l uld be det	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	underlying	cause give	en in Part I.			tobacco us Yes 2□		the cause of death? robably 4 Unknow
The law requires that the rate has been signed by the page 2 should be detached.	Completed									24a. Was auto perfo		prior to death?	utopsy findings availab completion of cause o
Physician: The this certificate ral director, pag	To Be (	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1  Inpai		ER/Outpatie			er: 4□Nu	rsing Hor	(Check only one 5 Resi	dence 6	Other (Spe	city) Hospice
Attending r death. sctor: After by the funer	Certification;	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide	28e. Place of li	1	28b. Time of Injury	М		yat k? Yes 2 □≀	No	28f. Location (			ural Route Number,
To the Hospitel or within 24 hours after To the Funeral Direction completely filled in I	edical Cert	29a. Certifier 1X Certifying Ph (Check only Medical Exer	ysician: To the bes	t of my kno	owledge, deat	th occurred	l at the tin	ne, date an pinion, deal	d place, a	and due to the	cause(s) a	and manner as place, and due	s stated. s to the cause(s)
To the P within 24 To the F complete	Med	one)	and manner of	stated.			c. Licens	o number			29d. Date	signed (Mont	h, Day, Year)
		30. Name and address of person who since the control of the contro	completed cause of	death (Iter	n 23a) (Tygo O Pu di	Print)	Ave	Muc	,#12	1 Av	inati	skis	
Si Regis	ate	31. Date filed (Month Day, Year)	004 32. Fégis	trar's Signa	ature	hack	R						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Lee Boso January 20, 5:00 a M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 11XM 2□ F 232-46-8542 73 Director 26, 1930 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Anne Arundel Arnold 1 ☐ Yes 2 ☑ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 Bay Green Drive 21012 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Pages 1 and 2 should be G. William Boso Madeline Morris 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other traugones. Beth Bennett/Daughter 306 Bay Dale Drive Arnold, MD 21012 Saltimore. January 22, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Lakemont Mem. Gardens 4 Donation 5 Other (Specify) 2004 Davidsonville, MD 21 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. 234. Lart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death emorrhagic Immediate Lause (Final disease of condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 M No 23d. Date of delivery 3 Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Artery Disease 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Obstructive Pulmonary 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has Hypertension 1 Yes 2 ₹No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Alter t 28c. Injury at Work? 5 Pending 1 Natural Injury after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerei C completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arundel Medical Center Shaw Anne 32. Pegistrar's Signature 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Voor **Physician** BROOKS CHARLES 2:00 am 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. Center If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Year) 1**10** M 2□ F 93 March 10 1910 Virginia Director 577-12-7475 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryles Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinal must be netitied at 1 ☐ Yes 2 ☐ No Director <u>Maryland Anne Arundel</u> Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 4 Melrob Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2X Married altimore, Maryland 21215-0020 Black 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance McGraw-Hill Co. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Colligan Milton Brooks 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 2 9 19a. Informant's Name/Relationship (Type, Print) (Neice) 4 South Rosedale St. Baltimore, Md. Florence Brooks-Je il ins 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Maryland National 4 ☐ Donation 5 ☐ Other (Specify) Memórial Park 1/30/04 Laurel, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Reese & Sons Mortuary, West St. Annapolis, Md. Wm. Diffeese MOOY83 821 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner myc the attending physician and thed for use es the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown á should be det à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes 2☑ No 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ this funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: : After I 1 Natural 5 ☐ Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide hours after To the Hospital
within 24 hours a
To the Funeral C 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1220 EAST JOPPA ROAD DORIS GRONAS SUITE 230 Towson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 Registrar

		-	State of Maryland / Department of Health a  1 - State Registrer Amend Item@3perDVRG828 2/11/04 EW Certificate of Death		giene 2004	04080
14			Decedent's Name (First, Middle, Last)	2. Date of Da Month	ath Day 2004	3. Time of Death
	Physicia /Medic		Robert Earl Brady	Janaua		6:45 P <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location or	f Death	4c. County of Dee	
			Anne Arundel Medical Center Annapolis  5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 2	24 Hrs. 8. Date of Bir		thplece (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year if Under 2 14-30-2661 7. Age (In yrs. last birthdey) Yrs.	Min. (Month, Da	y, Yeer) Co	ryland
ú)			Usuel Residence of Decedent	000.	1, 1929 120	272020
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ith the Marylan or 28a-f show	cto	Maryland Anne Arundel Annapolis			1 XYes 2 No
	ith th	Director	10e. Street and Number  14 Melrob Court  10f. Zip Code 21401		10g. Citizen of What Co USA	ountry?
	be filed within 72 hours after death with the Maryland tal Hyglene dother than "natural", or Items 23a or 28a-f show event, the Medical Exeminer must be natified at			nin? (Specify Vos or No		arican Indian
_	after dea or Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forcese?  11 Never Married 2  Married  12 Never Married 2  Never Married 3  Never Married 4  Never Married 3  Never Married 4  Never Married 4  Never Married 4  Never Married 5  Never Married 4  Never Married 5  Never Mar	, Puerto Rican, etc.)	Black, Whi	
20	hours after tural', or Ite al Exemina	by	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates: 1952–53   1 ☐ Yes 2 ☐ Yes 2 ☐ Yes		Specify:	White
9500-612	72 hours natural',	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of working	16b. Kind of Business	/Industry
7	within 72 ene. than na	nple	Elementary/Secondary (0·12) College (1-4or 5+)	-		
N	filed w Hygier Sther th		7th Service Technician	l r's Name (First, Middle)	Gas Compa	ny
and		Be	17. Father's Name (First, Middle, Last)  Robert Samuel Brady	_ `	erine Curta	in
	d 2 should be th and Mental 7 is marked traumatic ev	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number			
Mary	7575		Harrison L. Brady/ Brother 14 Melrob Court,	Annamolis	Maryland 2	1401
<u>o</u>			20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
E	Pages nent of int: If It ury or o		1   Burial 2AACremation 3   Hemoval from State	1-30-04	Edgewater,	MD
Baitimore,	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
<b>n</b>	88 = 88	1 1	Muttillule 2973 Solomons I	sland Rd. 1	Edgewater,	
			23a. Part1. Enter the disease, or complications that caused the death. Do not inter the mode of complications that caused the death. Do not inter the mode of complications shock, or heart failure. List only one cause on each line.		rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	ase.		
	/Medical Examiner		Due to or as, a constituence of):	ase.		
	遊	<u>ا</u>	Sequentially list conditions, b. Due to (or as a consequence of):			
	uted I Insit	Examiner	Cause (Disease or injury			
Ć,	exection and ital-tra	Exa	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed the has been signed by the attending physicien and organ 2 should be detached for use as the burtal-transit	cai	d			
Ó	ing ph	Medi	IF FEMALE:			
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant    1		23d. Date of de Month	livery Day Year
0	the a	ysic	1 Yes 2 No 9 Unknown 4 Pregnant all time of death 5 Other (specify)			
۵.	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	tobacco use contribute t	o the cause of death?
ds,	uires sign ld be	d by	Leelia 2	1 🗆	Yes 2 No 3 P	robably 4 Unknown
00	w require been si should t	Completed	Ceregal Delily	24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Re	sician: The law certificate has t lirector, page 2 s	E O		auto	ormed?   death?	s 2 No
ta	an: T	Be C	25. Was case referred to medical 26. Place	of Death (Check only		22110
⋝	ysici iis car dirac	To B	examiner?  1   Yes   2   No	rsing Home 5 Resi	idence 6 Other (Spe	ecify)
0 0	Attending Physician: ir death. ector: After this certified by the funeral director.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  28c. Injury at Work?		how injury occurred	
Sio	death. ctor: A	catio	2 Accident investigation M 1 Yes 2			
Division of Vital Records,	or Attendated of the Control of the	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and Number or R wn, State)	lurai Houte Number,
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date an	d place, and due to the	cause(s) and manner a	s stated.
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only one)    Check only one)   Check only one)   Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.			
	To the within To the Somple	Me	29b. Signature protitle of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)
			D570	128	01-28-0	14
			30. Name and a hire's of person who completed cause of death (Item 23a) (Type, Print)		2	
				SNAPOUS,	mo. dilli	81
	Sta Regist	ate	31. Date filed (Month, Day, Year)  JAN 2 9 2004			
145	ricgist	rai	The state of the s			

			For State Registrar	State of Ma	-	artment of Health and tificate of Death		2004	04081
	Dhamini		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		ETTA	CAREY	BLOX	DM	JANUARY	19,2004	8:20 a <sup>M</sup>
*	Examin		4a. Facility Name (If not institution, give st			4b. Cily, Town, or Location of Dea	ith	4c. County of Death	
14	4		229 Canal Park Dr.			Salisbury  If Under 1 Year If Under 24 Hr	S. 9 Date of Birth	Wicomico	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 1	M 21 F 84	(In yrs. last birthday) Yrs.	Months Days Hours Mir		0,1919 Mary	nice (state of Foreign /land
	D		Usual Residence of Decedent						
	urylan show	_	10a. State 10b. County		10c. City, Town or Lo	cation			0d. Inside City Limits 1   Yes 2   No
	8a-f	Director	Maryland Wicomico		Salisbu		100	. Citizen of What Cou	
	Mith ti	直	10e. Street and Number	7 40	\7	10f. Zip Code 21804	100	USA	itiy:
	eath	erai	229 Canal Park Dr.	2. Was Decedent E		Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ameri	can Indian,
8	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Modical Exemples must be routiled at	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	,   '	f Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☒ No <i>Specify:</i>	rto Rican, etc.)	Black, White, Specify:	etc. white
315-003b	hours tural		3   Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occupation	16	b, Kind of Business/In	
ņ	n nat	Completed	(Specify only highest grade	completed)	(Give	kind of work done during most of w DO NOT use retired)	orking		,
717	d within giene. ir then "	E	Elementary/Secondary (0-12)	College (1-4or 5+		maker	1	Domestic	
9	be filed ttal Hygi of other event, I	Bec	17. Father's Name (First, Middle, Last)				ame (First, Middle, Ma	iden Sumame)	
yland		To	Byrd Butler			Bessi			
Ma			19a. Informant's Name/Relationship (Type Randy Bloxom/son	e, Print)		ng Address <i>(Street and Number or F</i> 04 E. Clearlake		•	
altimore,	es 1 and 2 of Health of Item 27 i		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place)	Date 20	c. Location - City or T	own, State
Ē	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Departion 5 ☐ Other (Specify)	emoval from State			23/04	Salisbury,	MD
Balti	permit. Pages Department of Important: If it any injury or o		21. Sign of re of Funer II Service Livense	On me	22	Name and Address of Facility HOLLOWAY Funeral 501 Snow Hill Rd	Home Prof	essional A	ssociation
			33a. Part1. Enter the disease, or complic	ations that caused	he death. Do not ent				Approximate Interval Between
	Physician		shock, or heart failure. List only on		-	RU FAILL	188		Onset and Death
	/Medical		disease or condition resulting in death)						MUNI HI
	Examiner		Sequentially list conditions	ANYO	TRUPH	TC LATER	or scl	enons	1-5 ARM
	D ::	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):				
	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	consequence of):				
8760,	be e) ician buria	alE			_				
287		edical	d						
Box	death certific e attending p ed for use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		75-1		23d. Date of deliv	ery
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		Ectopic pregnancy Other (specify)	24 - 24	Month	Day Year
<u>т</u> О	that the de ned by the a	Phys	9 Unknown	-			ana Didasha		be seened of death?
	5 50	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause given in Part I.		cco use contribute to t 2 ⊠No 3 □ Prof	pably 4 [Unknown
Records,	w require been sig	Completed							nou findings available
2ec	sician: The law centificate has t irector, page 2 s	mpl					24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
	n: The ficate ha		25. Was case referred to medical			OO Plans of D	1 Yes 2	No 1 □ Yes	2 No
Vital	sicia certi	o Be	avaminar?	ospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	Other	eath (Check only one) Home 5-Residen	ce 6 ∏Other (Speci	(v)
10	g Phy er this eral c		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o		28d. Describe how		,
10	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	7 Joseph Inquity	M 1 Yes 2 No			
Division of	or Atterder de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, sti . (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of ter: On the basis of and manner stat	examination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner as s a and place, and due t	stated. the cause(s)
	o the ithin ( o the omple	Mec	29b. Signature and title of certifier	with institution state		29c. License number		I. Date signed (Month,	Day, Year)
)	F 3 F ŏ		Thichard	E. 1	not M	0 0-2213	2	1-20-0	4
)_	<b>L</b>								
	DIXCI	ate	30. Name and address of person who co  R C H ATOD E  31. Date filed (Month, Day, Year)  JAN 2 1 20	32. Registra	r's Signature	las V.	VI SAU	130,000	<i>p</i> - 0-7
	Regist		JAN 2 1 20	104 Ben	was p	ppour			

		4	State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hygiene Reg. No	~ 4004	04082
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da		3. Time of Death
	Physicia		Joanne Brown		Jan. 22,	2004	4:45 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	. County of Death	1
Н			105 E. Spruce St.	Delmar		Wicomi	
	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year	9. Birth	nplace (State or Foreign untry)
	Director		221-42-9369 48		7-22-1955	Md.	
	pu k	-	Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or L	ocation			10d. Inside City Limits
	hanyik	5	Md. Wicomico Delmar				XXYes 2 ☐ No
	28a-1	Director	10e, Street and Number	10f. Zip Code	10g. C	itizen of What Cor	untry?
	with with		105 E. Spruce St.	21875	1	SA	
	within 72 hours after death with the Maryland ene. Than "natural" or Items 23e or 28e-f ehow he Mudical Exeminer must be notitied at	by Funeral		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		14. Race - Amer	
(0	r Iter	필	1 Never Married 2 Married 1 ☐ Yes 2 Mo		Rican, etc.)	Black, White	), OCC.
ဗ္ဗ	al', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: Wh	ite
ပို	72 ho natur	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of work		(ind of Business/I	ndustry
2	thin ie.	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		1	
7	ed w ygjer ygjer yer th			stant manager	(First, Middle, Maide	tail Sto	ore
<u>n</u>	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)				
Maryland 21215-0036	d Mer narke	스	Wallace Melson  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ing Address (Street and Number or Rura	Devlin Mel		in Code)
Mai	12 st h and 7 ie n traun				mar, Md. 2		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ص	1 and Healt em 2	1	20a Method of Disposition 20b. Place of Disp	osition (Name of		ocation - City or	Fown, State
o	ages nt of t: If it		1 Burial 2 XCremation 3 Removal from State	matory or other place) y of Delmarva 1–26	-0/ De1	mar, De.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, In a Mudical Examination must be notified at once.	1				.mar, De	
Ba	Departing on it		A Torineel	2. Name and Address of Facility Short Funeral Home 13 E. Grove St. De		100//	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, of heart billure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	13340	Approximate Interval Between
	Dhusisian		turnations Course (Final	6.1			Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	100 lace			
	Examiner		Empyana				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events c.				
ó	e exe ian a urial-1		resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed the law remaining physician and the bas the burial-transit oace 2. Ihould be detached for use as the burial-transit	Physician/Medical	d				
9	n certific anding p use as t	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of deli	100
Вох	attend for us	ian	23b. was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	Day Year
0	at the de by the a tached t	ysic	1 Yes 2 2 No 9 Unknown	- Other (specify)			
0	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds,	uires sign	d by	Anerexic.		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Records,	requir been si hould	Completed	Course Conservance		24a. Was an	24b. Were au	topsy findings available
Re	The lavate has	m.	Coracted Carona		autopsy performed?	death?	completion of cause of 2 ☐ No
E		Ö	25. Was case referred to medical	26. Place of Deat	h Check only one	01 13.03	20110
5	Physician: this certific ral director,	0 8	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		me 5 Residence	6 □Other (Spec	city)
of		n: T	27. Man r of Death 28a. Date of Injury (Month, Day Year) Injury	of 28c. injury at Work?	28d. Describe how inj	ury occurred	
io	Attending I r death. ector: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No			
Division	for Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
	ital or ral Dir iled in						
	Hospital 4 hours : Funeral tely filled	edical	29a. Certifier (Check only (Check only (Deck only (Check only (Che	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause( ed at the time, date a	s) and manner as no piace, and due	to the cause(s)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Med	and manner stated.  29b Signature and title of certifier	29c. License number	29d. D	ate signed (Monti	h, Day, Year)
	¥ ¥ 8		ms ms	170172		1/21/10	4
•	_		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 4	-25	10-010	
D	Q		Awn DANS my 303-106 miku	d St. Scham	my 2180°	4	
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist		IAN 2 7 2004 Senera	sports			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year LOUISP Brown Jun 3:24 pm 2004 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Cantor Salisbur Wicomico Deev's Head If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 21 F 220-01-719 Usuel Residence of Decedent Director permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Health and Mental hygiene. Important: If them 27 is marked other than "naturel", or items 23s or 28s-f ahow any injury or other traumatic event, he Medical Emerical must be notified at any injury or other traumatic event, he Medical Emerical must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits WICOMIC 1 XYes 2 □ No **Funeral Director** FRUITLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 182 USA 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Black White etc. 1 ☐ Yes 2 Dt\no If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1□ Yes 2 No Specify: Completed by 3 Ø Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRED ATERS W ANNIE WRIGHT WATERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORK RD FRUTLAND Mb 21826 SHIRLEY WATERS~N 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burlat 2 Cremation 3 Removal from State EDEN. 4 □ Donation 5 □ Other (Specify) EMETARY 22. Name and Address of Facility BENNIE SMITH 21. Signature of Funeral Service Licensee 917 W ISABELLA ST. SAUSBURY. MD, 2/801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical 1 Week Examiner Physician/Medical Examiner Fewyeaks ete has been signed by the ettending physicien end pege 2 should be deteched for use as the buriel-trensit or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Lementia ģ Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No r deeth. 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hoepital or Att within 24 hours effer of To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Inja Hwang po Box 2018, PO MO Hwang Inja 31. Date filed (Month, Pay, Year) 32. Registrar's Signature 1 2004 State Registrar

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Mary	land / Dep		Health and	Mental Hygi	_	04085
М			Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
			Georgette Jo	Bruneau				Jan. 21	Day Year	4:00 AM
			4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town,	or Location of Deat		4c. County of Death	
	Itel or Attending Physician: The law requires that the death certificate be executed its after death.  Itel or Attending Physician: The law requires that the death with the Maryland is after death. Itel be within 72 hours after death with the Maryland in a state death with the Maryland in a second in a se		5626 Oak Place			Bet	hesda		Montgome	rv
	Funeral				yrs. last birthday)	If Under 1 Year Months Days			Year) 9. Birth	place (State or Foreign ntry)
	Director		210-01-0832	1□M 2 <b>X</b> ]F	55 Yrs.			Feb 13,	1948 Fr	ance
	pur *		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	faryli eho	٦ ·								1 ☐ Yes 21 No
	28a-1	ect	Maryland Montgor  10e. Street and Number	nery	Bethesda	10f. Zip Code		10	g. Citizen of What Cou	
	with a or	ā	5626 Oak Place			20817		"		intery :
	ns 23	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			Specify Yes or No-	France	can Indian.
	r Her	표	1 ☐ Never Married 2 🔯 Married	Armed Forces? 1 ☐ Yes 2 📉 No		_		Specify Yes or No- to Rican, etc.)	Black, White,	etc.
3	urs a		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify: Whi	te
12-003b	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occu	pation	rtina 1	6b. Kind of Business/Ir	dustry
N	thin e	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of wo	, and		
7	ygier ygier yer th			4	Bus	siness Ma	,		Xerox Comp	any
yiand	ital H d ott		17. Father's Name (First, Middle, Las	7)				me (First, Middle, M	aiden Sumame)	
y Ia	Men Men Marke	မ	Raymond Rodet					illordin		
Mar	2 sh and ie m		19a. Informant's Name/Relationship						City or Town, State, Zij	Code)
dî.	1 and 1eeltl 1m 27		Hilarion Bruneau		5626 Ob. Place of Dispo	Oak Plac	e-Betheso	da, Maryla		0
Baitimore,	or of		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or other pla			Oc. Location - City or To	
	Carrier P		`4 □Donation 5 □Other (Special				atory 1-2		exendria,	Virginia
o n	Depa mpo mpo nny is		21. Signature of Funeral Service Lice	0.11.0	2	2. Name and Addre	ess of Facility D	eVol Fune ast Deer	ral Home Park Drive	
			22a Bury Enter the disease or one	All Vol	dooth Donat on	to the mede of de	Gait	hersburg,	MD 20877	Approximate
	/Medical	34	23a. P. v. Enter the disease, or con- ck, or heart failure. List only lmm liate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leaving to immediate	a. Metastat  Due to (or as a co	ic Breas					Interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	cai	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a co						
O. Box	0 8 9	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
rds, P	quires that an signed b	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	underlying cause gr	ven in Part I.		cco use contribute to t	he cause of death?
ecord		piet						24a. Was an	24b. Were auto	ppsy findings available
r	The I	E						autopsy perform 1 Yes 2	ed? death?	mpletion of cause of
VII	an: tifica tor, p	0	25. Was case referred to medical				26. Place of De	ath (Check only one		20 140
	ysici is cer direc	.0	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Ot			ce 6 Other (Special	€)
0	g Ph ler th neral		27. Manner of Death	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time o	of 28c. Inju		28d. Describe hov		,,
0	ndin ath. r: Aft	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		a) injury		Yes 2 □No			
DIVISION	7 2 2 2	Certific	3 Suicide 6 Could not l		At home, farm, st pecify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	he Hospi in 24 hour he Funere pletely fills	edicai	29a. Certifier 1X Certifying P (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	a, and due to the cau urred at the time, dat	ise(s) and manner as s e and place, and due to	stated. o the cause(s)
	To t To t	Σ	29b. Signature and telepof certifier			29c. Licen	se number	290	d. Date signed (Month,	Day, Year)
	10		CXXXX n			2027	70	Ja	nuary 21,	2004
			30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Print)				
			Claudine Isaacs			r Rd., N	.W. Wash.	, D.C. 20	0007	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Some				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frances Bowler January 24, 2004 6:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 28, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕏 F 569-42-3933 81 Sept. Director Missouri Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena. At 18 it 18 ma 23 is marked other than "natural," or items 23 is or 28e-f show 10c. City, Town or Location orient: In them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic svent, the Medical Examination at Exception 1. 10b. County 10d. Inside City Limits Funeral Director 1 Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 333 Russell Avenue, 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Postal Elementary/Secondary (0-12) College (1-4or 5+) Public Information Officer Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion O. Butcher ٩ Nellie L.F. Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If Item 27 is
sny injury or other trau Charles R. Thompson/Friend 14424 Myer Terrace, Rockville, MD. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial
Park 20a. Method of Disposition January 29, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2004 Rockville, Maryland 21. Signature of Finneral Service Licenses 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) day **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Dav Year 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown the Funeral Director: After this certificate has been simpletely filled in by the funeral director, page 2 should in Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury all Work? 28d. Describe how injury occurred 1. Najural 5 Pending investigation 1 Tes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Registrar

31. Date filed (Month, Day, Year) JAN 28 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Leo Shue, M.D.

32. Registrar's Signature

MID

9901 Medical Center Drive, Rockville, Maryland

29c. License number

D60557

29d. Date signed (Month, Day, Year)

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** John William Bausch 22 January 2004 7:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13131 Triadelphia Mill Road Clarksville
If Under 1 Year | If Under 24 Hrs. Howard 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⋤**M 2□F Director 579-09-5644 85 Jan. 6,1919 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location item 27 is marked other than "neturel", or iteme 23s or 28s-1 show other traumatic event, the Wedical Examination to could be 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ₩ No Director Maryland Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13131 Triadelphia Mill Road 21029 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours affer of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Item 1 □Yes 2 No 1 ☐ Never Married 2 ∰ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lobbyist Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ Carl Bausch Marguerite Leahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Nora Bausch 13131 Triadelphia Mill Road. Clarksville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State 1 StBurial 2 ☐ Cremation 3 ☐ Removal from State injury 4 □ Donation 5 □ Other (Specify) Jan. 27, 2004 Silver Spring, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Kuchard of Hatio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only anel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D 50870 January 26th 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print); Bell in Clarksulle MI) 5005 signal Abdo Shram 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Buch JAN 28 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 06088 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:20 AM Lillian Ardella Becker January 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing & Rehab. Ctr. Chestertown Kent | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. B | Min. | Nov. 10, 1913 | W. 9. Birthplace (State or Foreign Country) W. Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ VF 90 Director 233-22-8675 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "netural", or items 23a or 28e-f show the Medical Examination must be exitting at 1 X Yes 2 □ No Director Rock Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21305 Lee Street 21661 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Billing / Collections Hecht Company 12th other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be is marked o Mental Lewis Henley Cora Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Leroy Becker, Jr. 21661 P.O. Box 166, Rock Hall, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6 permit. Page Department of Important: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Meadowridge Cemetery 1/19/2004 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PARKMSCY **Physician** 10150ASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 🗌 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: After Division Attending 5 Pending 1 / Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signajure and title of certified 1-16-64 10013824 30. Na e and address of perso / o completed cause of death (Item 23a) (Type, Print) John C. Seymour, M.D. 122 Speer Road Chestertown, Md. 21620 31. Date filed (Month, Day, Year) 32. Regig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #5, 02/09/04, T.M. Kent CState of Maryland / Department of Health and Mental Hygiene
Amended # 8 1 - State O1/29/04, T.M. Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 900 2004 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. 07/1918 R Hospita hester erte 6. Sex / 1 M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Mary Land Director 05 **排5. 579-16-9072** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No aryland
10e. Street and Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgnec Road 21620 USA. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status tiled within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cryptologist National Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be tilt Department of Health and Mental Hy Important: If item 27 is marked oth any liuty or other traumatic event 2008. 17. Father's Name (First, Middle, Last)
Libert J. Borradaile Mae L. Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert Borradaile, Jr./Son 1201 Palm Drive, Rehobeth Beach, DE 19971 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ↑☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Stevensville Cemetery 1/28/2004 Stevensville, MD 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 Kick & 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY DISEASE Pnysician CHIZONIC CRSTPUCTIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certiticate be executed and Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown signed by Division of Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DUERMONIA 1 Yes 2 No 3 Probably 4 Unknown SPINAL OSTE OPUNOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETER MELLITUS performed 2 X No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 12 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this tours after death.

neral Diractor: After this filled in by the tuneral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/2 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0041587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Chestertown, MD 21620 31. Date filed (Month, Day, Year) 32. Regimar's Signature State JAN 2 8 2004 Registrar

						of Man	yland / Depa <i>Ce</i>	artment of rtificate of				Reg. No.	2111	) 4	04090
1	Physicia /Medica		1. Decedent's Nam  Lee Mar	e (First, Middle, Etin Ben	,						2. Date of D. Month  Januar	Day	, 20°C	'ear )4	3. Time of Death 11:02AM
1	Examine	-	4a Fecility Neme (I	f not institution,	give street end no	ımber)			4b. City, T	Town, or Lo	ocation of Dea	th 4c.	County of	Death	
					Hospital				Che	steri				Ken	
- 46	Funeral Director		5. Social Security N 198-48-	-3789	S. Sex M∑ M 2□ F	7. Age (/	In yrs. lest birthday) 45 Yrs.	If Under 1 Yea Months Deys		or 24 Hrs. Min.	8. Date of Bi (Month, D Sept.	irth ay, Yea <i>r)</i> 23,	1958	D. Birthpl Count Net	ace (State or Foreign try) W Jersey
	within 72 hours after death with the Maryland ene. than 'naturel', or items 23a or 28a-1 show ha Madical Examiner must be notified at		Usuel Residence of 10a. State	10b. County		10	Oc. City, Town or Lo	ecation						10	Od. Inside City Limits
	Ba-1 s	ᅙ	MD.	Ke	nt		G	a1ena							1 DXYes 2 □ No
	igh th	2	10e. Street end Nur	mber				10f. Zip Code				10g. Citiz	zen of Wh	et Count	try?
	ath w	ā		ıth Main				216					USA		
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health end Mental Hygiene. Important: If fem 27 is marked other than "naturel", or flems 23a or 28a-1 show any injury or other treumatic event, the Madical Examinar must be notified at page.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri	iod 2⊡ Marrio	12. Was Dec	edent Eve orces? 2)(1) No	er in U,S. 13.	Was Decedent of If Yes, specify Cu	Hispenic C ban, Mexica	rigin? (Spe an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,	White, e	
21215-0020	urs af	b	3 Widowed		If Yes, G Year or I	ive		1□Yes 2XDNo	Specify	<b>y</b> :			Specify:	Wh:	ite
9-0	2 hou	9	(C	15. Decedent's	Education grade completed		16a. Dece	dent's Usual Occu	pation			16b. Kir	nd of Busin	ness/Ind	lustry
2	thin 7	흔	Elementary/Seco			(1-4or 5+)	life.	kind of work done DO NOT use retir	ed)	SE OF WORK	ing	Mon	santo	)-As	orow
	ygien ygien t, th	် ပ	12			<u> </u>	A	gronomos	_			<u> Div</u>	<u>isior</u>	<u> </u>	Prow
Maryland	12 should be filed within h end Mental Hygiene. 7 is marked other than " freumatic event, the Me.	a	17. Father's Name		•						e (First, Middle		Sumame)		
Ž	hould d Mer marks	٤	Alfred 19a. Informent's Na		ett, Jr.		105 14-33	ng Address (Stree			se Post		. T		0.41
₹	then treu			Za1esk	, , , , ,										NJ. 07838
<u>6</u>	s 1 end 3 I Health tem 27 i	1	20a. Method of Disp	position		[:	20b. Place of Dispo cemetery, cre			II NO	Date		cation - Ci	_	
Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 eny injury or other to DRCS.		1 ☐ Burial 2 I	Cremation 3 5 ☐ Other (Spe	Removal from	State	Chesapeak			1	/28/04	Stow	anewi	110	, Maryland
alti	mit. I partm porter / inju	Ì	21. Signature of Fu												Home, P.A.
8	Department of the property of		Kuk	12	Elglen	lu	) 1	30 Speer	Roac	i, Che	esterto	own, l	runer Maryl	and	21620
	jā.		23a. Part T. Enter to shock, or hea	he diseese, o co rt failure. List or	omplications that nly one cause on	caused the each line.	e death. Do not en	er the mode of dy	ring, such a	s cardiac o	or respiratory a	arrest,		4	Approximate Interval Between Onset and Death
h	Physician /Medical Examiner		Immediate Cause ( disease or condition resulting in death)	(Final in	e. CA	RDIZ	pulseum e to (or as a consent the Ablu	elly A	exect	<b>-</b>				1	
	D 45				. Mes	43/4	tic Aseu	verran	rua	op e	elin.			1	
68760,	ificate be executed g physician end as the burial-transit	edical Examiner	Sequentially list confidence if any, leading to imcause. Enter Under Ceuse (Disease or that initiated events	nditions, nmediate orlying injury	c	Du	e to (or as a consec	uence of):							
Box 68	- O 6 .	_	resulting in death) I	Last	d	Due	e to (or as a consec	dence or).	_						
	the a	380	Part II. Other signif	icant conditions	s contributing to d	eath but n	ot resulting in the u	nderlying cause g	iven in Parl	t I.	23b. Did	tobacco	use contri	ibute to	the cause of death?
, P.O	that the ned by a detection	y L	TOBACO	eo Ava	Alcoho	e A	Bure	_			1 🗵	Yes 2	□ No 3	☐ Prob	ably 4 🗆 Unknow
of Vital Records,	The law requires that the death certate has been signed by the attending page 2 should be deteched for use	Completed by Physician/N									24a. Was	s an autop	sy 2	ava	re autopsy findings ilable prior to appletion of cause
Rec	ohasb ge 2 s	E					-					/	7	of d	leath?
ā	certificate		25. Was case refer	red to medical					OC Plan	<del></del> (D			□No	1 🗆	Yes 2□No
5	Physician: this certific	0 26	examiner?	/	Hospital:	Inpatient	2 ☐ ER/Outpatier	t 3 DOA O	thor:		n <i>(Check only</i> me 5□ Res		Other	/Snacity	4
0	g Phy er this eral c		27. Manner of Deatl		28a. Date (Mor						28d. Describe				/
<u>ö</u>	arth. r: Aft	a110	1 ☑Natural 2 ☐ Accident	5 Pending investigat	tion	in, Doy 16	ear) Injury		Yes 2	□No					
Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	ad 200. Place	e of Injury ing, etc. (5	- At home, farm, str Specify)	eet, factory, office	)			(Street and wn, State)		or Rural	Route Number,
	To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funerel Director: Affer this certificate hat completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	aminer: On the b	e best of m asis of exa oner stated	ny knowledge, deetl amination end/or in I.	occurred at the treestigation, in my	ime, date a opinion, de	and place, a eath occurre	and due to the ed at the time,	cause(s) date and	and mann place, and	er as sta d due to	ated. the cause(s)
	Vithi To th		29b. Signature end	title of certifier  Our	bel of	M.	8.		se number				e signed (I		Day, Year)
		-	30. Neme and addre	ess of person wh	no completed cau	se of deeth	h (Item 23e) (Type,	Print)		-					
			John E. Ar.	entism	m. ms.	223	High Street	- CHESE	How	n, Wi	ul 21	620			
K	State Registra	e r	John & Ar. 31. Dete filed (Mont	JAN 2	8 2004	Registar's	Signature	Sperks							
					1	#**		-							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 🤈 0409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:00 A M MILDRED **THERESA** BAUER JANUARY 21 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FOREST HILL

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. MARINER HEALTH OF FOREST HILL HARFORD 8. Date of Birth (Month, Day, 6/15/] 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 217-18-6863 190 Maryland 98 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic event, the Medical Exerct as must be notified at 1 Yes 2 No Director MD. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 Sunflower Drive United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: 3XXWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Office Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finance and Mental F 2 William Ludwig Cora May (unknown) 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 Is nany injury or other traum Ellen F. Bauer/ -in-law 102 Waldon Rd. Apt.G 21009 Abin don, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/28/2004 Pikesville, Maryland ^ 4 □ Donation 5 □ Other (Specify) Druid Ridge Cem. 21. Signature of Funeral Service Leaves 22. Name and Address of Facility Jarrettsville, Maryland Suce. Nen E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Anterrosclerotie Cardiovusular disease **Physician** /Medical ue to (or as a consequence of) **Examiner** Derlen STON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ue no or as a consequence of): Examiner attending physician and for use as the burial-transit or as a consequence of): Next Wes that initiated events resulting in death) Last P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mo Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 0 No 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 🗌 Yes Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2/01/10 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After within 24 hours after death.

To the Funerel Director: After completely filled in hours. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year) 29c. License number who completed cause of death (Item 232) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar JAN 2 7 2004

			1 - For State Registrar	State of Maryla	-	artmer rtifica			nd Me		ene g. No.	2004	+ 04092
Н	Physici	20	Decedent's Name (First, Middle, Las						1	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		John	Cesto	2				į	January			10:08 A M
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of	Death		4c. C	ounty of Dea	th
			Anne Arundel Medic			+	Annap				1	nne Ar	
	Funeral Director		5. Social Security Number 6. Security Number 11 217–32–2401	7. Age (In yi	rs. last birthday, Yrs.	Months	n 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, March 4	<sub>7ear)</sub> ,193	9. Bird Co Was	thplace (State or Foreign buntry) Chington, DC
	land ow		10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits
	within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28a-f ehow fra Mudical Enerthine maal te mulified at	Director	Maryland Anne A	rundel	Edge	ewate:	r p Code			10	a. Citiz	en of What Co	1 ☐ Yes 2 X No
	an or	ā	1610 Millstone Dr:	ivo			2103	27			-	USA	,
	ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Dece			in? (Spec	ify Yes or No- ican, etc.)		4. Race - Ame	erican Indian,
21215-0036	urs efter al', or Ite	É	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ₩ Pivorced	Armed Forces? 1XIYes 2 □ No If Yes, Give Year or Dates:1960		If Yes, spe		n, Mexican, Specify:	, Puerto R	can, etc.)	5	Black, Whit Specify:	white
Ŏ	2 ho	Completed	15. Decedent's Ed	ucation	16a. Dece	edent's Usu	al Occupa	ation	-6		6b. Kind	d of Business	
21,2	Pin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	onk done d ise retired,	furing most )	or working	,			
2	gien.	Son		4 yrs.	Gener	cal Co	ontra	ctor			Roc	fing	
	should be filed withir nd Mental Hygiene. marked other than imatic event, ITEM	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name (	First, Middle, N	laiden S	lumame)	
<u>a</u>	should be and Mental s marked o umatic eve	2	Anthony Cest	tone				J	ane 1	1cCann			
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours elter death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any finitry or other traumatic event, the Medical Evantival must be rectified at ance.		19a. Informant's Name/Relationship (7  Christine M. Wilso		40400		27100-20-0 EU			Route Number, Jewater			
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition  1 ☐ Burial 2 【Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	o. Place of Dispo cemetery, cre Kalas Cr	osition (Na matory or	me of other place	9)	–25–(	te 2	Oc. Loc	ation-City or water,	Town, State
=======================================	permit. Pag Department Importent: I eny Injury c		21. Signature of Funeral Service ico	*					100				ral Home
ä	Depa Impo eny Ir		Mulkelle										MD 21037
}	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a.	neum			g, such as c	ardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death Ont week
à l	Examiner		Sequentially list conditions,	Due to (of as a cons	Lasis								5 years
,	ate be executed hysician and the burial-transit	Examiner	at any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons									
68760,	icate be physicia s the bur	cal		d.		_						ĺ	
×	leath certificat attending phy I for use as th	W/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy						22	d. Date of del	in/An/
.O. BQ	es that the death cer igned by the attendin be detached for use	by Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown		⊒Ectopic p ⊒ Other (s <sub>i</sub>						Month	Day Year
S, D	The law requires that the death certifics sete has been signed by the attending propage 2 should be detached for use as it		Part II. Other significant conditions co	ontributing to death but not r	resulting in the u	anderlying o	cause give	n in Part I.		23e. Did tob			o the cause of death?
Ö	w requir been si should	lete								24a. Was an		24h Were a	itopsy findings available
Vital Record	ysician: The lavis certificete has director, page 2	Completed								autopsy perform		prior to death?	completion of cause of
<b>\frac{1}{2}</b>	Physician: this certificantal director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	Ar.		Check only one			
o	Phys this ral di	- To	1 Yes 2 No	1 Hipatient 2 28a. Date of Injury	ER/Outpatie		DA 28c. Injury	4 LI Nur		d. Describe how			cify)
on	ding h. After fune	tion	1 Natural 5 Pending	(Month, Day Year)		M	Work	i? ∕es 2∐N		d. Describe rior	w injury	occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm, st poify)					f. Location (Str. City or Town,	eet and State)	Number or Ru	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier 1. Certifying Phy (Check only one)	ysician: To the best of my kiner: On the basis of examinand manner stated.	knowledge, deal ination and/or in	th accurred avestigation	at the tim	e, date and inion, death	place, an	d due to the cal at the time, da	use(s) a te and p	nd manner as lace, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and Itle of certifier				c. License			29	d. Date	signed (Monti	h, Day, Year)
1	->-0		MIND				105	-18	19	/	/2	5-/09	·
_			30. Name and a ress of person who of	CT. S	rite	Print) Ma	tthe	w Malt	ta, /M	13D. M 1	)	214	6/
	Sta Registi		31. Date liled (Month, Day, Year)	32. Projistrar's Sig	nature	book	-						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Dav **Physician** EVELYN D. COTTMAN JAN 20, 2004 /Medical 6AM 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Salisbury Rehab and Nursing Center Salisbury, Md. Wicomico | Honder 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Supplementary | Min. | July 13, 1908 5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F 9. Birthplace (Stete or Foreign Country) Maryland 7. Age (In yrs. lest birthdey) **Funeral** Months Days 95 Director 219-03-7627 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at 1⊠ Yes 2□ No Funeral Director Maryland Wicomico Salisburv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Riverside Drive, Apt. B211 21801 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer Domestic Depertment of Health end Mental Hyg Important: If Itam 27 is mental Hyg any Injury or a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SPENCER OUINTON ANNIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) William James Cottman, Jr. 1016 Sheridan Ave., N. - Minneapolis, MN 55411 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ \*Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gdns 01/24/2004 Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) METASTATIC MONTH Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORONARY DISEASE ARTERT 2 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? TLIYOS 2 THU 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours efter deeth. To the Funeral Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 2 9168 17-0all. 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) M. D. ROBERT ALLEN 1346 S. Division St. Suite, Salisbury, Md. 21804 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 3 2004 Registrar

**DHMH 16 Rev 6/95** 

EVELYN COTTMAN

			1 - For Amend Item Registrer	11 State of M	aryland	Cei	irtment of the	lealth and M Death	fental Hygid Reg	ene 200	4 04094
	Dh		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Ye	3. Time of Death
	Physici /Medic		HOL CLI	NTON CA	YTON				JANUARY		
	Examin		4a. Facility Name (If not institution,					r Location of Death		4c. County of D	
			1301 Belmont Av			a birahada . N	Salis If Under 1 Year	-	8. Date of Birth	Wicom	
ı	Funeral Director		219-38-9214	5. Sex 7. Ag 12 M 2 F 8	je (In yrs. la:	Yrs.	Months Days	Hours Min.	(Month, Day,		Birthplace (State or Foreign Country)  Orth Carolina
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation				10d. Inside City Limits
	Aaryli f sho	ō	Maryland Wico	mico		lisbur					1 ☐ Yes 2 ☑ No
	28a-	rect	10e. Street and Number	III.CO	Sal	risour	10f. Zip Code		10	g. Citizen of What	t Country?
	3a of	Funeral Directo	1301 Belmont A	ve			218	04		USA	
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. V		ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian,
21215-0036	ba filad within 72 hours after death with the Maryland tial Hygiene. Id other than "naturel", or Items 23a or 28a-f show evant. The M-dicul Exa-right frust by muffled at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced				Tes, specily Cuba	Specify:	nicall, etc.)	Specify:	white, etc. white
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual Occupa	during most of work.	ina 10	6b. Kind of Busine	ess/Industry
2	within ene.	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NDT use retired)									
72	a filad v Il Hygie other t		10 17. Father's Name (First, Middle, L			Milit	ary	18 Mother's Name	(First, Middle, Ma	J.S. Nav	Υ
and	d ba f	Be c	Issac	Duff	Cator	1		Ella	Tino		
Maryland	s 1 and 2 should be Health and Mental tem 27 is marked o other traumatic eve	ဥ	19a. Informant's Name/Relationshi				g Address (Street a	and Number or Rura			te, Zip Code)
	nd 2 ilth a 27 Is r tra		Suzanne C. Bern	s/daughter		1307	Belmont	Ave., Sa	lisbury,	MD 21804	4
ē,	item othe		20a. Method of Disposition		20b. Pla		sition (Name of natory or other plac			Oc. Location - City	
Ē	Page nant c ant: If ury or		1 ☐ Burial 2 ☒ Cremation : 1 ☐ Donation 5 ☐ Other (Specific Control of Contr				Cremato	I	/04	Salisbur	y, MD
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service L	Annee	FTD	22 H	Name and Address OLLOWAY I	ss of Facility Funeral H Hill Rd.,	ome Profe	essional	Association
	_		23a. Part1. Enter the disease, or o	omplications that cause	the death.						Approximate Interval Between
	Physician		shock, or heart failure. List o	ny one cause on each i		1-	1.	Melos	uma		Onset and Death
П	/Medical		disease or condition resulting in death)	a Due to (or as			with	, ,,,,,	-071-04		- 1 4/5
ı	Examiner		Sequentially list conditions	b							
	Sit sid	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	nce of):					
	tificate be executad ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):					
68760,	icate be execu physician and s the burial-trai										
687	ficate physis the	edical		d							
Box	death certif e attending id for use a	ZW.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	су	_			23d. Date of	delivery
_	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			Ectopic pregnancy Other (specify)			Month	Day Year
<u>Р</u> .	at the by th	hys	9 🗆 Unknown	9□ Unknown							<del></del>
Vital Records, I	law requires that the death cer as baen signad by the attendin 2 should be detached for use	by	Part II. Other significant condition	s contributing to death b	out not result	ing in the ur	iderlying cause give	en in Part I.	23e. Did toba 1 ☐ Yes	11	e to the cause of death?  Probably 4 Unknown
eco	a law requir has baen si je 2 should	Completed							24a. Was an autopsy	prior	a autopsy findings available to completion of cause of
E	Thate ate	Con							perform 1 ☐ Yes	ed? death <del>I</del> No 1□\	
Vit?	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		(Check only one)		
o	<u>ਦ</u> ≑ ਦ	; To	1 Yes No	1 L Inpatie		R/Outpatien 8b. Time of	3 DOA	4   Nursing Ho	me Sesiden 28d. Describe how		ipecify)
on	ding th. After	tion	Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Date)	y Year)	Injury	28c. Injury Work M 1 🗆 `	k?` Yes 2 □ No		and a second	
Division	or Attending after death. Director: After in by the funer	Certification;	3 Suicide 6 Could no determin	t be 28e. Place of In	ury - At hom c. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
_	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Ce	29a. Certifier Certifying (Check only one)	Physician: To the best ceminer: On the basis o and manner st	f examinatio	edge, death on and/or inv	occurred at the time	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner e and place, and c	r as stated. due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner st	u.ou.		29c. License	e number	290	d. Date signed (Mo	onth, Day, Year)
	F ₹ F 8		I Bull De	The			D36	576		1/22/00	7
4			30. Name and address of person w	ho completed cause of o	leath (Item 2	23a) (Type. I	Print)				r
2			RONALD P.	TRAVITA				ERS (DE	DR S	HL'SBU	RY UCO 21801
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu		Spark				7
	Registr	ar	JAN 2 2	2004 Des	wa	B	pour				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. WiCHD, dq State of Maryland / Department of Health and Mental Hygiene For State Registrar Admend#19b, Per FH, 01-26-04 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nu 4b. City, Town, or Location of Death Examiner UNIVERSIT MKI) BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 75 APR.16,1928 LEWES, DELAWARE 222-12-1510 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits liner must be notified at 1 Yes 2 No Director LEWES DELAWARE SUSSEX 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19958 USA 6 CAREY LANE Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
ant: If item 27 is marked other than "natural, or Ite,
any or other traumatic event, IIIs Macked the factorial 1 Never Married 2 Married WHITE 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PROPANE GAS COMPANY TANK TRUCK DRIVER 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANK CAREY ALICE McCHESNEY 2 MARGARET B. CAREY P. WILE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HART B. CAREY / WIFE 6 CAREY LANE, LEWES, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State permit. Page Department of Important: If any injury or 01/23/04 LEWES, DE ST. PETERS CEMETERY ¹ 4 □Donation 5 □ Other (Specify) M00866 21. Signature of Funeral Service Licensee PARSELE TUNERAL HOMES & CREMATORIUM Letth Farsel 1449 KINGSHIGHWAY, LEWES, DE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown ģ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and Mile of certifier ddress of person who completed cause o death (Item 23a) (Type, Print)

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

the Hospital or Attending Physicien:

death.

death with the Maryland

Baltimore, Maryland 21215-0036

or 28a-f show

Items 23e

State Registrar

31. Date filed (Month, Day, Year) IAN 2 1 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BILLY RALPH JANUARY 24, 2004 3:20P. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Jan. 31, 1937 Birthplece (State or Foreign Country) 1₩ 2□F 66 Yrs. Director 238-56-2622 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County r than "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Prince George's Beltsville Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13132 Oriole Drive 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) State Farm Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Insurance Agent Insurance Co. permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lonnie Creech Naomi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeAnn Barsy -Daughter 6695 Seagull Court Frederick, Maryland 21703 Baltimore. 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Durial 2 Cremation 3 Removal from State George Washington Cem. 1/31/2004 Adelphi, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses onald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Left Lung Pneumonia w/ Pleural Effusion /Medical Due to (or as a consequence of): **Examiner** Ischemic heart disease w/ old myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Dav Year 5 Other (specify) detached 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1XYes 2 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0010660 January 26, 2004 8 WEUZL 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) R. Weber, M.D. 1828 Greene Tree Road, #500 Baltimore, Maryland 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 29 Septera Registrar sacks!

			1 - For State Registrar	State of Ma	aryland / [	Depa Cer	artment of F tificate of	leaith and I <i>Death</i>	Mental Hygi	ene 2 () g. No.	04	04097
	Physici /Medio		1. Decedent's Name (First, Middle, Last) GEORGE V		FORD				2. Date of Death Month Jan	Day 7, 2	ŏ°å 4	3. Time of Death 1:26 Rm
7	Examir	er	4a. Facility Name (If not institution, give s Shady Grove Adv	,	Hosp.		4b. City, Town, or ROCKV	r Location of Death 111e	1	4c. County		erv
100	Funeral Director		5. Social Security Number 6. Security Number 232-40-2473	7. Age M 2□F	7 4	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Aug 12.	-	9. Birthp	lace (State or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	cation				1	Od. Inside City Limits
	Maryl	tor	Md Montgon	nery			ckville					1√EXYes 2 □ No
	or 28s	Director	10e. Street and Number	-			10f. Zip Code		10	g. Citizen of W	/hat Coun	try?
	s 23a		313 Seth Pla			1 40 1	20850			U.S		
36	be filed within 72 hours after death with the Maryland hat Hygiene. nd other than "natural", or Hems 23a or 28a-1 show event. The Myslical Exertine must be incitified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 12 Yes 2 14 If Yes, Give Year or Dates:	lo	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 1 No	ispanic Origin? (S) in, Mexican, Puert Specify:	Decify Yes or No- Dican, etc.)		Americ k, White, d	etc.
2	72 hours "natural",	eted	15. Decedent's Edui	cation		Deced	ent's Usual Occupa	ation	king 1	6b. Kind of Bus		
21215-0036	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done of PO NOT use retired nouter S		(MIG	Canit	01 [	ental ©.
Q	filed Hygi other	0	12th Grade 17. Father's Name (First, Middle, Last)			COI	ipucer L		ne (First, Middle, M			rental w.
/lan	Mental Mental Arked o	To B	William Cr	rawford				Mag	gie Jef	ferso	n	
Maryland	2 sho		19a. Informant's Name/Relationship (Ty)		1.0				ral Route Number,			
e,	1 and Health tem 27		Loretta Crawi  20a. Method of Disposition	ord (Wi	fe) 20b. Place of	Dispos	sition (Name of		Rockvil	le, Mo		
E O	Pages nt: # 11		1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	1		natory or other plac n Memori			Rockvi	•	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any injury grother treumatic events.	6	21. Signa ure of Funeral Service License	n mode	w Ls		Name and Address Snowder	s of Facility Tumera	al Home gton St,	P.A.	2085	50
5	#.		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused ne cause a each lin	the death. Do n	not ente						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Aca	te/	17	ound	1 1	Mond	for		Onset and Death
	/Medical Examiner		Tesuming in dealin)	Due to (or as a	a consequence of	of)(	Pot-	- /	1 ins	_		Kom,
B		ner	Sequentially list conditions, if any, leading to immediate		consequence	01):		7	- (J~7)		- (	
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	)								
58760,	ficate be executed physicien and s the burial-transit	ai E		Due to (or as a	a consequence o	и):						
_	ificate g phys as the	edicai	0	1.								
.O. Box	The law requires that the death certific to has been signed by the attending proage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 1 1 □ Live birth 1 2 □ Pregnant at 1 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
o,	quires that t n signed by uld be detac	by	Part II, Other significant conditions con	ntributing to death bu	it not resulting in	the un	derlying cause give	en in Part I.			bute to the	e cause of death?
Record	ysicien: The law require is certificate has been si director, page 2 should b	Completed							24a. Was an autopsy performe	pr de	ere autoprior to comeath?	osy findings available appletion of cause of
ital	cian: ertifica octor, p	BeC	25. Was case referred to medical examiner?						h (Check only one)			-
<b>d</b>	Attending Physician: ir death. ector: Atler this certifics by the funeral director.	5	1 ☐ Yes 2 No H	lospital: 1  Inpatier 28a. Date of Injur		_	3 DOA Othe	4   Nursing no	ome 5 Aesiden 28d. Describe how			)
O	nding Ph th. : After th s funeral	tion	1 Statural 5 Pending 2 Accident investigation	(Month, Day		njury	Work	rat (? Yes 2 □ No	280. Describe now	rinjury occurre	u	
Division of Vital	al or Attends after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	rm, stre	et, factory, office		28f. Location (Stre City or Town,		r or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funaral Directorpletely filled in by	edical (	29a. Certifier 15 Certifying Phys (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination and	, death	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and man e and place, ar	ner as stand due to	ited. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	5) (	11/	7	29c. License	number	290	d. Date signed	(Month, E	Pay, Year)
	12/		Millen	conty	110		123	1 16/	( \(\sqrt{1}\).	ANUNY	2/6	7,2004
	( "		30. Name and address of person who co  Dr William					/	- P	/	7	/ /
*	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	90]	Medica	L_Cente	er Dr, B	OCKVÍ	rre,	Ma 20850
	Registr	ar .	JAN 3 0 20	114	EN I	had	proude	Zac				

State of Maryland / Department of Health and Mental Hygiene 2004 0408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ricardo **Physician** January , 2004 21 /Medical 4a. Fecility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 53 Yrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F 215-98-0105 11-12-50 Peru Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show injury of other traumatic event, the Medical Examiner must be notified at 11 Yes 2 No Director Gaithersburg Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Itams 23a 9207 Hummingbird Terr. U.S.A. 20879 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married ö Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Peruvian "natural", Hispanic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Item 27 is marked other then any injury og other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Pastor Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antenor Chavez Mercedes Agreda 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Irma Chavez - Wife 9207 Hummingbird Terr. Gaithersburg, MD 20879 20b. Place of Disposition (Name of cometery, crematory or other place)
Loudon Park 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 1-25-2004 | Balt., MD 21. Signature of Funeral Service Licena 22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave., Silver Spring, MD 20904 lan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Difficile Colitis Clostridium Physician 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate that underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. F been signed by the a should be detached f 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Scieroderma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an page 2 autopsy performed? certificate 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Npatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 X Natural 5 Pending s after death.
I Director: Aft
d in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Director Completely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) i mile Thor M.D. RES-000 January 21, 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EricMiller Thorn, 601 North Caroline Street, Baltimore, MD 21205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks JAN 28 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SOUKANE CHANTHAKHOTH JAN. 27, 2004 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Yrs Director 212-45-9790 86 LAOS Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. snt: If item 27 Is marked other than "neturel", or Items 23e or 28e-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director PRINCE GEORGES MD. RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5608 SIGNET LA. 20737 LAOS by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced ASIAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BUILDER 12 CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, PrinDAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOYSANGVANE MOUNGKHOUNSAVATH/ SIGNET LA., RIVERDALE, MD. 20737 5608 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Importent: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHAMBERS CREMATORY 1-31-2004 ' 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. 21. Signature of Funeral Service Kicensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS SYNDROME /Medical Due to (or as a consequence of): Examiner RECURRENT PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል page 2 should be RESPIRATORY FAILURE, CHRONIC OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY DISEASE, DYSPHAGIA, DIABETES MELLITUS certificate has 2 No Division of Vital 1 Yes Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) our D53367 JAN. 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAMSUNDAR, DARNESTOWN RD. #202, GAITHERSBURG, MD. 20878 M.D. 10810 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 2004 ocikal Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4:20 AM 23, 2004 George N. Chaconas January /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Randallstown Randallstown Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Director 78 Jan.27,1925 Washington, DC 578-22-1127 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mental Hygiene. Important: if tem 27 is marked other then "natural; or items 23a or 28e-f show any injury of other traumatic event, the M-dical Examinar mast be notified at anotice. 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Funeral Director** Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2513 Avalon Place 20783 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 Tes 2 No Specify: <u>ک</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's Elementary/Secondary (0-12) College (1-4or 5+) Bailiff 12 County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Nicholas K. Chaconas Angelina Pettis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 2513 Avalon Place Hyattsville, MD 20783 Grace A. Chaconas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/27/04 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 ns the caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, so no ch line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical lucur Examiner Due to (or es e consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) for use es Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 1 types tension 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No Medical Certification: To this To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclen: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifie 29d. Date signed (Month, Day, Year) ono 30. Name end eddress of person who completed c use of death (Item 23a) (Type, Print) 1838 Greens Tree Rd en 31. Date filed (Mohth, Day, Year) 32. Registrar's Signature State JAN 28 2004 Registrar

				land / Depa	artment of Health an rtificate of Death	d Mental Hygi		04101
	Physic		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	/Medi		Emile Robert Cardin			January		1824 <sup>M</sup>
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D	eath	4c. County of Deal	
			Union Hospital of Cecil Cour	nty	Elkton		Cecil	
	Funeral		177 M 00 C	yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth	O Rin	hplace (State or Foreign
	Director		039-22-5778 <sup>¹™™ 2□F</sup> 68	Yrs.	Months Days Flours	June 8,	1935 Rhd	de Island
	D >	1	Usual Residence of Decedent  10a. State 10b. County 10c	01				
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examinar must be medical	-	Tob. County	c. City, Town or Lo	cation			10d. Inside City Limits
	Ba-f	Funeral Director	Maryland Cecil	North	East			1 ☐ Yes 2/∑XNo
	iff the	100	10e. Street and Number		10f. Zip Code	. 10	g. Citizen of What Co	untry?
	23a	-E	39 Yarmouth Lane		21901		United St	ates
	de de	in e	11. Marital Status 12. Was Decedent Ever Armed Forces?	1	Was Decedent of Hispanic Origin's f Yes, specify Cuban, Mexican, Po	(Specify Yes or No-	14. Race - Ame	rican Indian,
ထ္ထ	afte or it	五	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No	1954 EO	I ☐ Yes 2 🖾 No Specify:	dello rilogni, etc.)	Black, White	
ğ	ours rel',	9	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1956	TEN 2 2 20 140 Specily.		Specify: Wh	iite
21215-0036	72 h	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most of	working 1	6b. Kind of Business/	Industry
7	ithin Je.	ם	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)			strial
	filed w Hygier other th	ပ္ပ	12 4	Senio	or Technical Rep	presentativ	e Chemi	icals
힏	be filed within 72 hours after death with the Marylan stal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Evanting must be confifted at	Be	17. Father's Name (First, Middle, Last)		18. Mother's I	Name (First, Middle, Mi	aiden Sumame)	
<u>ya</u>	should be filed withir nd Mental Hygiene. I marked other than umatic event, the Ma	မှ	Emile Oscar Cardin		Mary I	ouise Paul	hus	
Maryland	C a a a		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or	Rural Route Number,	City or Town, State, 2	ip Code)
2	1 and 3 Health tem 27 other tr		Margaret Cardin/Spouse	39 Ya	rmouth Lane, No	rth East,	Marvland 2	1901
altimore,	permit. Pages 1 and Department of Heal Importent: If Item 2 any injury or other 2005.		1M2	b. Place of Dispos cemetery, crem	sition (Name of	Date 20	oc. Location - City or	
Ĕ	Page nent int: If		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	St. Mary	Anne's Jan	uary 29,	N 1 T	
=======================================	mit.		21. Signature of Foneral Service Licensee	Cemetery 22.	. Name and Address of Facility			t, Maryland
m	Deg in a co		) Island Ga		•		neral Home	
			23a. Part1. Enter the disease, or complications that caused the	death. Do not ente	South Main Str	diac or respiratory arres	east, Mar	yland 21901 Approximate
			Immediate Cause (Final			nao on roopinatory arres		Interval Between Onset and Death
<b>*</b>	Physician /Medical		disease or condition resulting in death) Myocar	dial Inf	arction			1 hour
	Examiner		Due to (or as a cor	sequence of):				
		70	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of:				
	ted sit	Examiner	cause. Enter Underlying Cause (Disease or injury	sequence or).				
	and and II-trai	хап	that initiated events c. Due to (or as a con	sequence of):				
8760,	ate be executed hysician and the burial-transit			000,000				
	centificate be executed inding physician and ise as the burial-transit	dical	d					
9 X	eath certific attending p	Physician/Med	IF FEMALE: 23b Was decedent program: 23c If yes, outcome of pre	anana.			1	
Вох	death of	lan	in the past 12 months?	etal death 3 🗆	Ectopic pregnancy		23d. Date of delive	rery Day Year
o.	0 0	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5∐	Other (specify)		No.	Day 16a1
ı.	law requires that the as been signed by th 2 should be detache		Part II. Other significent conditions contributing to death but not		4-14	00- 00-		
S,	ires t signe	þ	Takin Sular significant containers contributing to death but not	resulting in the un	deriying cause given in Paπ I.		cco use contribute to	
5	w require been sli should b	ted				- 1 ☐ Yes	2 □ No 3 □ Pro	bably 4 X Unknown
ဝ	law lasb	현				24a. Was an autopsy	24b. Were aut	opsy findings available
Vital Records,	sician: The law certificate has l irector, page 2 s	Completed				performe	d? death? No 1 ☐ Yes	
Ξa	Physician: this certific	Be	25. Was case referred to medical examiner?		26. Place of D	eath (Check only one)		-2
0	Physic this ce al dire	ဂ္ဂ		2 ☐ ER/Outpatient	3X DOA Other: 4 ☐ Nursing	Home 5 Residence	e 6 □Other (Speci	fy)
			27. Manner of Death 28a. Date of Injury 1 X Natural 5 ☐ Pending (Month, Day Yea.	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
DIVISION	Attending r death. ector: After by the fune	atle	2 ☐ Accident investigation	, , , , , ,	M 1 ☐ Yes 2 ☐ No			
Ĕ	er de recte by t	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	t home, farm, stre	et, factory, office	28f. Location (Stree City or Town, S	at and Number or Run	al Route Number,
2	rs aft	Ce		,,		Ony or rown, o	naio)	
	hou uner uner	dical	29a. Certifier  (Check only (Check only 2 X Medical Exeminer: On the basis of exam	knowledge, death	occurred at the time, date and pla	ce, and due to the caus	e(s) and manner as s	tated.
	the H in 24 the F iplete	e e	(Check only one) 2K Medical Exeminer: On the basis of examiner and manner stated.	ination and/or mye	estigation, in my opinion, death oc	curred at the time, date	and place, and due t	o the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
			· alua Sulis	MUD	D58313		January 2	300%
17	11111		30. Name and address of person who completed cause of death (	tem 23a) (Type, P			candary Z	7, 4004
_/	FIVA		Laura Ellis, Union Hospital,	106 Bow	Street, Elkton.	Marvland 2	1921	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Si	ggature	,			
	Registra	ar	JAN 2 8 2004 Blown X	selle!				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Ma	ai yiai id	•			Death	vicinal Fly	Reg. No. 20	04	Control of the contro
hysician /Medical		Decedent's Name (First, Middle, La	<sub>st)</sub> Francis Pa	trick	. Cas	ey			2. Date of De Month Janua	Day	Year 2004	3. Time of Deat 22:00
xaminer	4	Facility Name (If not institution, give	4	4b. City, Town, or L								
neral ector	5. 3	Calvert Manor He Social Security Number 6. S 074-32-7694		Center e (In yrs. Ia: 75		/) If Und Month	er 1 Year Days	Rising S If Under 24 Hrs. Hours Min.	(Month, D	Cec rth ay, Year) 29/1928	9. Birthp Coun	lace (State or Fore
220	-	ual Residence of Decedent a. State 10b. County		10c. City,	Town or I	ocation					1	0d. Inside City Lim
or led		MD Cec	il		sing							1 ☐ Yes 2 ☐
Director	10	e. Street and Number					ip Code			10g. Citizen of V	Vhat Coun	try?
ai D		1881 Telegraph	Road				2191	1		USA		
edical Examiner must be notified at leted by Funeral Director	11.	Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		. 13	If Yes, sp	edent of H ecify Cuba 2 <table-cell> No</table-cell>	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	o- 14. Rac Blac	e - Americ ck, White, Whit	etc.
		15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	i+)	(Giv life.	e kind of v DO NOT		ation during most of won	king	16b. Kind of Bi		
E		12 Father's Name (First, Middle, Last,	1		Ma	chin:	st	18. Mother's Nam	ne (First Middle		troni	CS
raumatic event, the M To Be Comp	i I	James Casey							cine Gar		,e,	
traumatic	19	a. Informant's Name/Relationship (	Type, Print)		19b. Ma	ling Addre	ss (Street	and Number or Ru			State, Zip	Code)
. •		Louise Phillips			4 F	enn '	/iew	Dr., West	Grove	PA 1939	0	
r other	20	a. Method of Disposition	Dames of from State	20b. Pla	ce of Disp netery, cr	oosition (A ematory o	ame of other place	œ)	Date	20c. Location -	City or To	wn, State
ury or		1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification)		Ox.fc		emet				Oxford		
any injury or other	21	. Signature of Funeral Service Licer	Man	1				<sup>ss of Facility</sup> Edv 86 Pine				
	23	Ba. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. ne.	Do not e	nter the m	ode of dyin	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
cian lical iner	di	nmediate Cause (Final sease or condition sulting in death)	a. End	Stag	e A	the equence o	mers	Demen	ha		 	3 years
ial-transit Examiner	Se	equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease of injury	b	Due to (or a	do a cuito	equence o	).				1	
s the bur	Ca tha re	resulting in death) Last  Due to (or as a consequence of):									<u> </u>	
detached for use as			d									
ched	Pa	rt II. Other significent conditions of	2	ut not result	ting in the	underlying	cause giv	en in Part I.				the cause of dea
be deta		Trigeminal 1	Jeuralgia						1	Yes 245-No	3 □ Prot	oably 4⊡Unkn
2 should	_									s an autopsy ormed?	ava	ere autopsy finding ailable prior to mpletion of cause death?
rector, page									10	Yes 25 No	10	]Yes 2□No
Be Be	25	. Was case referred to medical examiner?	Meanital				Out	26. Place of Dea	th (Check only	one)		
	٠	1 ☐ Yes 2 ☑ √ 0  . Manner of Death  . Natural 5 ☐ Pending investigatio	Hospital: 1 Inpatie  28a. Date of Inju (Month, Day	ry 2	R/Outpati 28b. Time Injury	of	28c. Injur Wor	4 Erwursing H		idence 6 □Oth how injury occur		/)
led in by the funeral Certification:		3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	ne, farm, s	street, facto	ory, office			(Street and Numb wn, State)	er or Rura	l Route Number,
pletely fill edical	29		ysicien: To the best on niner: On the basis of and manner sta	examination								
W Combo		b. Signature and title of certifier	6.0			2	9c. Licens			29d. Date signe		Day, Year)
		prashest on	ikla				0000	48050		1/27	104	
5		Name and address of person who Prashant Shukla	completed cause of d	eath (Item 2	23a) (Type	e, Print)	et #	400 Ab	erdeen	m 0 210	100	
State	31	. Date filed (Month, Day, Year)	32. Registra	ar's Signatu		1.						

			1 - For State Registrer	State of Maryla		artment of rtificate o			Reg. No	4001	04103
	Physici /Medio		1. Decedent's Name (First, Middle, La Roberta Col	isi) Wan Cond	1:4			2. Date of Month	Death Da ペラ		3. Time of Death
)	Examir			e street and number)    Spita   Center   Sew   7. Age (In yrs   M 2   XF   86		4b. City, Town		Hrs. 8. Date of (Month,	Birth Day, Year)	County of Deat	th hplace (State or Foreign unitry)
	Director		108-14-4686  Usual Residence of Decedent  10a. State 10b. County		Yrs.			July	14, 19		V York
	ier death with the Marylan Hems 23a or 28a-f ehow Lef mast be rediffed af	Director	MD. Queen	n Anne's		ertown			- <del></del>		1 ∏ Yes 2 □ No
	ith with the 23a or 2 unit be or	ral Dire	10e. Street and Number 221 Old Bridge Ro	oad		10f. Zip Code	.620		10g. Cit	tizen of What Co	
980		by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 MÃNo If Yes, Give Year or Dates:	•	Was Decedent of If Yes, specify C		? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: Wh	
Baltimore, Maryland 21215-0036	iene. r than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during most of ired)	working	Car	ind of Business/ rro11-Co t Galler	ondit
land	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last Robert Cowan	)		•	18. Mother's	Name (First, Midd nelia Mar	1100011100	,	
Mary	ges 1 and 2 should 1 of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (George L. Condit.		1			r Rural Route Num Chester			zip Code) and 21620
nore,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	Removal from State	Place of Dispo cemetery, crea	osition (Name of matory or other p	o/ace)	Date	20c. Lo	ocation - City or	
Baltin	permit. Page Department important: If any injury or once.		21. Signature of Funeral Service Lice	Jerlein )	F <sub>3</sub>	3. Name and Add 130 Spee	Helfenber Road (	in & New Chesterto	mam I own, N	Puneral Maryland	Home P.A.
,	Physician		23a. Part 1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Finel disease or condition	111.	ith. Do not en	ter the mode of o	tying, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						3
8760,	sate be executed thysician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
O. Box 6	the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	Ectopic pregnal Other (specify)				23d. Date of deli Month	very Day Year
rds, P	uires tha signed d be de	þ	Part II. Other significant conditions of	contributing to death but not re					d tobacco u		the cause of death?
of Vital Records,		Completed						24a. W au pe 1 ☐ Yes	topsy rformed?	prior to death?	topsy findings available completion of cause of 2 \square No
Vita	Physician: 1 this certifical rai director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1. Inpatient 2 □	ER/Outpatier	nt 3 DOA	)ther	Death <i>(Check onl</i> ng Home 5 ☐ Re		6 ∏Other (Spec	eify)
Division of	ling After une	ertification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. In		28d. Describ			
Divis	tal or Attend rs after death ai Director: ed in by the f	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	reet, factory, offic	ce		(Street an Town, State		ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filted in by	edical	29a. Certifier (Check only one) (Check only one)	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date and pl y opinion, death o	lace, and due to the occurred at the tim	ne cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
	To the h within 24 To the Complete	Σ	29b. Signature and title of certifier	Day ES			onse number			te signed (Month	n, Day, Year)
			30. Name and address of person who	completed cause of death (Ite d MD (00 E 32. Regil ar's Sign	m 23a) (Type,	Print) St. Cl	restortor	on WD	2162	0	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 8	32. Registar's Sign	ature //	Spelle					

		1	State	State of Marylar	•	rtment of He			iene 2004	0404
			Registrar  1. Decedent's Name (First, Middle, Last)			modito of D	Julin	2. Date of Deat	h	3. Time of Death
	Physicia			1106A W	ILLLIA	ms co	OPER	Month	Day 24 2504	1 /2:36 AM
	/Medic		4a. Fecility Name (If not institution, give st			4b. City, Town, or I	Location of Death	7/4/4-4/	4c. County of Deeth	
	Examin	er	0		Care	18	ESTERT	EWN	KEN	7
_			5. Social Security Number 6. Sex	7. Age (In vis	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9. Birth	place (State or Foreign
	Funeral			M 200 F	7 Yrs.	Months Days	Hours Min.	(Month, Day, MARCH	Year) 1916	MD MD
Į.	Director		Usuel Residence of Decedent				1	TO THE CO.	0,11.9	
	land ow	1	10a. State 10b. County	10c. C	ity, Town or Loc	eation				10d. Inside City Limits
	Mary	0	MD KEN	T	WOR	ron				1 X Yes 2 No
	288 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	with with		10715 1610	RTON R	OAD	21	678		U.S.A	١
	in 72 hours after death with the Maryland "naturel; or itema 23e or 28e-f show exical Exertine man be notithed at	Funeral		2. Was Decedent Ever in I		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Amer Black, White	
	fter c	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 No	1			rican, etc.)		
2	hours after tural', or ite	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	'	☐ Yes 2 No	Specify:		Specify: W	HITE
ş	2 hou	Completed	15. Decedent's Educ			ent's Usual Occupa kind of work done di		ina	16b. Kind of Business/	ndustry
212	- C C	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ilife. C	OO NOT use retired)		9	11.	
77	filed with Hygiene ther the	Eo				HOMEMI	4 EER		HOMEM	AKKR
g		Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ā	should be nd Mental marked o	To B	RALPH PORTE	R WILLI			SAI		COPPER	
Maryland 2	shot and M is mai	-	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailin	g Address (Street a	nd Number or Run	al Route Number	r, City or Town, State, Z	ip Code) 21620
	5 C P 5		CARRIAN CO	OPER	127	N Que	een Str	847 C	HESTERTO	GM, Was.
<u>6</u>	_ + # # #		20a. Method of Disposition	1	Place of Dispo-	sition (Name of natory or other place		Date	20c. Location - City or	Town, State 21623
9	Pages nent of int: If it iry or o		1 Burial 2 □ Cremation 3 □ Re  1 □ Donation 5 □ Other (Specify)	moval from State	_ ′	R CEMET	1 1 1 1	7/04	CHESTERTI	OH, MD
altimore,			21. Signature of Funeral Service License			Name and Address		5 GREEN	U HEREN W	21620
ä	permit. Departr Imports any inju		Man I Wel		i	IARVIN U	WILLIA	este Tr	Funeral I	pirector
			23a. Part1 Enter the disease, or complic	cations that caused the de						Approximate Interval Between
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	12115	MARKE	1)E	MENT	Tia	Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	C/JE	11/2/01	~	7—17	7 47	1 3
	Examiner			Due to (or as a const	squorioo orj.					
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	ted	ulu	cause. Enter Underlying Cause (Disease or injury							
	xecu and	Examiner	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):					
8760,	ate be executed obysician and the burial-transit									
387	icate phys s the	dical								
9 X	ding Se as	Me	IF FEMALE:	3c. If yes, outcome of preg	nancy			*	23d. Date of del	ivery
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
0	the the	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		, , , , , , , , , , , , , , , , , , , ,				
ď	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	by Physician/Med	Part II. Dther significant conditions con	tributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds,	signe signe							1 🗆 Y	es 2₽No 3□Pr	obably 4 DUnknown
oro	regu	Completed						24a 14faa	an 24h Ware a	stoney findings available
ec	law lasb	npl						24a. Was autop	sy prior to death?	completion of cause of
<u> </u>		Cor							2 No 1 Yes	22 No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referre medical examiner?	Landali		Othe	26. Place of Deal	th (Check only o	ne)	
Division of Vital Records,	S S D	2	1 ☐ Yes 2₽ No		☐ ER/Outpatier	and the same of th	4 Z Nursing H		lence 6 ☐Other (Spe	city)
0		ü	27. Man → of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	κ?	28d. Describe n	now injury occurred	
<u>%</u>	Attanding r death. actor: Afte	ati	2 Accident investigation				Yes 2 □No			
Σį	f or Attandatter deatl	ertiflcation;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, sti <i>cify)</i>	eet, factory, office		City or Tox	Street and Number or Ri vn, State)	urai Houte Number.
	spital or At ours after o varal Dirac filled in by	O								
	e Hospital of 24 hours af e Funaral Dietely filled in	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exami	sician: To the best of my k	nowledge, deat ination and/or in	h occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	, and due to the or rred at the time, o	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the Hosp within 24 hor To the Funs completely fi	led	on	and manner stated.		29c. License			29d. Date signed (Mont	
	To To	Σ	b. Signature and ti of certifier	10)					200. Date signed (MOIII	Juj, . Jui/
			Count -	July 1	m	U,	3605	Y		
			30. Name and address of person who co			Print)	Ore - O	O C AC	MINTA	h. h. A
_			PATRICK	SHOWAY		1200	0 02	0 008	HENTEN	1153
		ate	31. Date filed (Month, Day, Year)	2004 32. Registar's Sig	gnature	hand .			2	16 70
	Reaist	16:16	17 11 1 W	Colored Livery Or was	A TOP	A CONTRACTOR AND AND				

Departed Home First Mode, Let   10   2004   11   11   12   12   12   12   13   10   10   10   10   10   10   10			l	1 - For State Registrar	State of M	aryland				ealth a Death	and M	_	giene Reg. No.	200	) 4	04	105
Find a Scannicry  Service Serv		Physici	an	1. Decedent's Name (First, Middle, La	st)						_			Ye	ar	3. Time o	of Death
Solid Bendy Note   Solid Bendy	3											_				7:1	5 A <sup>M</sup>
Second Security Number   Second Security Number   Second Security Number   Securit		Examir	er					4b. City, 1	Town, or	Location of	of Death		4c.				
TO STATE A SHOP TO STATE A SHO								W11.									
Control   Cont							• • •				Min.	(Month, Da	y, Year)				
The state of the control of the cont		Director		577-28-8393	- "	81	115.					Jan. 26	<u>, 19</u>	$22 \mid V$	Vash	. D	C
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part		fand				10c. City,	Town or Loca	ation							10	d. Inside C	City Limits
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part		Hary Hary	ō	Maryland Prince	George's			В	owie	<b>:</b>						1 💢 Yes	2 □ No
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part		288 288	Je.	10e. Street and Number		1		10f. Zip	Code				10g. Citi	zen of What	Countr	v?	
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part		3a o	ā	3607 Violetwood	D1ace				2	0715						-	
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part		ms 2	era		12. Was Decedent	Ever in U.S	. 13. W	as Deced			gin? (Spe	ecify Yes or No		14. Race - A	merica	n Indian,	
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part	9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2127				TT		, Puerto	Rican, etc.)	İ				
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part	03	ref., c	by	3 Widowed 4 Divorced	Year or Dates:		11	⊥Yes 2	Z∐ No	Specify:				Specify:	B1a	ıck	
Process   Part   Part   Part   Process   Part   Process   Part   Part   Process   Part	5-0	72 h	etec				16a. Decede	nt's Usua	l Occupa	ation	t of worki	na .	16b. Ki	nd of Busine	ss/Indu	istry	
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	2	ithin	npi	Elementary/Secondary (0-12)		5+)	life. DO	) NOT us	e retired,	)							
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	2	ygier ygier her tl	S					Fed	eral						ernn	nent	
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	ī	be fill	Be							18. Mothe	r's Name						
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	<u>Y</u>	ould Men Parke	2			ı											
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	Jai	2 sh and Is m			•												
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such		l and lealth im 27 her t			- Husband	Joh Bla				lills							20748
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	0	ges If of H			Removal from State		metery, crema	tory or ot	her place	9)		/ale	20c. Lo	cation - City	orlow	n, State	
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	Ë	trmen tent: jury				Ceda										MD	
23a. Part 1 Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the death of the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such as cardiac or respiratory arrest, indicated the mode of dying, such	3ali	ermit Pepar npor ny in		21. Signature of Funeral Service Lice	nsee												
Physician   Medical Examiner	_	0 □ F € Ø		John 1. )	Kees and	سللا								., DC	20	019	
Template   Template		/Medical Examiner	aminer	Immediate cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. <u>Gen</u> Due to (or as	ery)	12 <i>C</i> / ence of):										
Female:   23b. Was decodent pregnant in the past 12 moghts?   1   Ves 2   No   1   Live birth 2   Feral death   2   Fe	Ő,	e exe	EX	resulting in death) Last	Due to (or as	a conseque	ence of):										
Female:   23b. Was decodent pregnant in the past 12 moghts?   1   Ves 2   No   1   Live birth 2   Feral death   2   Fe	876	ate b hysic the bi	lica	•	d										-		
25. Was case referred to medical examiner?	O. Box 6	the death certific y the attending p ched for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1⊡Live birth 4⊡Pregnant a	2 Fetal c	death 3□E						2				Year
25. Was case referred to medical examiner?	٥	that led by deta		Part II. Other significant conditions	contributing to death t	out not result	ting in the und	lertying ca	ause give	n in Part I.		23e. Did to	obacco u	se contribute	e to the	cause of	death?
25. Was case referred to medical examiner?	sp.	uires I sigr	Q D									101	es 25	3No 3□	Probal	oly 4 🗌	Unknown
25. Was case referred to medical examiner?	Ö	A required should be shoul	iete						•			24a Was	an	24h Were	autons	y findings	available
25. Was case referred to medical examiner?	Ä	has ge 2	ш									autop	SV	prior	to com	pletion of d	ause of
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   1/22/64   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   1/22/64   1	a	(9		OF Mes once referred to madical										101	es 2	□ No	
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   1/22/64   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   1/22/64   1	Ę	sicia certi recto	00	examiner?	Hospital:		D/O		Othe								
Davidh Joldman, M. D. Dood 4374 122104  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 105  David M. Goldman, 7500 Hanover Parkway, Green be 1+, mp 2072	o	Phy r this ral d	T				<del></del>		^	4 🗆 Nu					pecify)		
Davidh Joldman, M. D. Dood 4374 122104  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 105  David M. Goldman, 7500 Hanover Parkway, Green be 1+, mp 2072	0	ding h. Afte fune	tion	1 ☑Natural 5 ☐ Pending	(Month, Da	y Year)											
Davidh Joldman, M. D. Dood 4374 122104  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 105  David M. Goldman, 7500 Hanover Parkway, Green be 1+, mp 2072	Divisi	el or Atten s after deat l Director: d in by the	ertifica	3 Suicide 6 Could not b	e 28e. Place of In	jury - At hom tc. (Specify)	ne, farm, stree	et, factory,							Rurali	Route Nun	nber,
Davidh Joldman, M. D. Dood 4374 122104  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 105  David M. Goldman, 7500 Hanover Parkway, Green be 1+, mp 2072		e Hospit 24 hour e Funere letely fille		(Check only 2 Medical Exa	miner: On the basis o	f examination	ledge, death on and/or inve	stigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the o	cause(s) date and	and manner place, and o	as stat	ed. he cause(s	5)
Davidh Joldman, M. D. Dood 4374 122104  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 105  David M. Goldman, 7500 Hanover Parkway, Green be 1+, mp 2072		withir re th	Me	29b. Signature and title of certifier				29c.	License	number		(	29d. Date	signed (Me	onth, D	ay, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 105  Dav. IM. Goldman, 7500 Hanover Parkway, Green be 1t, mg 2072		$(\Lambda)$		10 - 1h	Haldre		m.D.	1	MAZ	1 H	37	4	1/2	2/04	1		
JC Dav. IM. Goldman, 7500 Hanover Parkway, Green belt, mg 2072		(10)		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type, Pr	rint)	UUC	14	105						
		TO		^ 1 1	1 1	, 75	00 Ha	nove	erf	arku	val	Gree	nb	elt.	m	0 20	フス
Registrar JAN 2 7 2004					32. Registr	ar's Signatu	ire	'	•		-						

			1 - For State Registrar	State of Ma	aryland				lealth a Death	and M		giene Reg. No.	201		The state of the s	06
	Physic		Decedent's Name (First, Middle, Last)     Aida	Diaz					-		2. Date of Dea Month January	Day	200	′eer )4	3. Time of 9:55	
	/Medi Examir		4a. Facility Name (If not institution, give s 4425 Cannes Lane	011				4c. County of Death Montgom								
ą	Funeral Director		210 00 0550	7. Ag	e (In yrs. Ia. 87	st birthday) Yrs.	If Unde Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day Nov. 14	(, Year)	916		olece (State or otry) iba	r Foreign
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom	erv		Town or Lo	ocation							1	10d. Inside Cit	•
	with the a or 28e Le roll	Director	10e. Street and Number 4425 Cannes Lane			J	10f. Z	p Code	20020	<u> </u>		10g. Citi	zen of Wh		ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23e or 28e-f show amounts; if yiny or other treumatic event, the MacKetal Examiter in all the multiple and once.	by Funeral		12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:			Was Deci If Yes, sp		20832 ispanic Origin, Mexican Specify:	gin? (Sp	ecify Yes or No- Rican, etc.)		14. Race -	Americ White,	can Indian, etc. hite	
Maryland 21215-0036	d within 72 hor piene. r then "neturi the Musical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		5+)		dent's Usi kind of w DO NOT	ork done d use retired	ation during most ()	t of work	ing	16b. Ki	nd of Busi			
yland ;	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Horacio Rodriguez		•						(First, Middle, Luisa I		Sumame)			
, Mar	and 2 sho salth and ? n 27 is me		19a. Informant's Name/Relationship (Tyg. Ms. Aida Chaviano			4425	Can	nes I	ane,		al Route Numbe ⊇y, Mary			ate, <i>Zip</i> 832		
altimore,	Pages 1 nent of He ant; if iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ce of Disponence					2004		cation - Ci t imo r		own, State Maryla:	nd
Balt	permit. Departi Import any inj		21-Signature of Funeral Service License	~ 00	to	$\searrow$ 1	1800	New	Hamps	shire	nes-Rina Av., S	ilv				
15 (F)	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		the death. .monar				g, such as	cardiac	or respiratory arr	est,			Approximate Interval Betw Onset and D 2 hour:	ween Death
	/Medical Examiner		Sequentially flat conditions if any, leading to immediate	Due to (or as  Me to  Due to (or as	astat	ic Lu	ing C	ancer								
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	,	amous	Cell	. Can	cer c	f Lun	ıg						
O. Box 68	ath certifi attending   for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3	∃Ectopic p ∃Other (s					2	23d. Date o Month		,	'ear
rds, P.	n requires that the deben signed by the should be detached	by	Part II. Other significant conditions con	tributing to death b	ut not result	ing in the u	nderlying	cause give	en in Part I.						ne cause of de	
Division of Vital Records,		Completed									24a. Was a autops perform	SV	prio	r to cor th?	psy findings a npletion of ca 2 No	ivailable iuse of
f Vita	ıysicien: Th iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	ospital: 1 🗌 Inpatie	nt 2 E	R/Outpatien	nt 3 D	Othe Othe	20		n (Check only on me 5 🕅 Reside		5 □ Other	(Specify	r)	
sion o	Attending Physicien: r death. sctor: After this certific by the funeral director,		27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju- (Month, Day	ry Year) 2	8b. Time of Injury	f M	28c. Injury Work 1 🔲 `	at (? Yes 2 🗆 N		28d. Describe h	ow injury	occurred			
DIVIS	afte Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)						28f. Location (SI City or Town	n, State)				er,
	To the Hospitel within 24 hours and the Funerel completely filled	edical	29a. Certifier 1 X Cartifying Phys (Check only 2 Medicel Examin one)	ician: To the best of ar: On the basis of and manner sta	examinatio	edge, death in and/or in	h occurred vestigation	at the tim	ie, date and pinion, deat	d place, a th occurr	and due to the c ed at the time, d	ause(s) ate and	and mann place, and	er as st I due to	ated. the cause(s)	
)	To the within 2 To the complete	Me	29b. Signature and title of certifier  **Manual Company Compan	Achi	varb	, HC		c. License	01736	8	2				Day, Year) , 2004	
ستنا	•		30. Name and address of person who countries Stanley A. Schwar	tz, M.D.	545	4 Wis		n Av	e., #	1345	, Chevy	Cha	se, l	MD 2	0815	
	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signatu	19	S	ock	21							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 6:45 PM Arlena January 21, 2004 Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Prince Georges Heartland Health Care Center-Adelphi Adelphi If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Rep. 1907 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Months 1 □ M 250 F 96 579-44-4435 Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ty⊡ Yes 2 □ No Director Maryland Prince George's Hvattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6030 Sargent Road Apt. #5202 20782 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0020 Black Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Nurses Assistant Georgetown Hospital 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred Blair Leah Lewis 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Arlene Chambers (cousin) 6921 Georgia Ave. N.W., #205, Wash. D.C. 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/30/04 Suitland, Maryland 4 Donation 5 ☐ Other (Specify) Lincoln Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Advanced Dementia. Immediate Cause (Final disease or condition resulting in death) /Medical Examin r Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yas 2 0 Mo To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No edical Certification: To 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00054566 30. Name and eddress of pers will completed cause of death (Item 23a) (Type, Print) TOWSON, 17/12/28/ Suilla Bhogaville 1220A East TOPPaRoad 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Gener JAN 28 2004 Registrar

DHMH 16 Rev 6/95

maris.

		•	1 - For Registrar	State o	f Marylan			t of Heal		nental Hyg	giene Reg. No.	2004	02 08
			1. Decedent's Name (First, Middle	, Last)						2. Date of Dea		Year	3. Time of Death
	Physici: /Medic		JOHN	R. DA	VENPOR'	$\mathbf{T}$					21,	2004	1930 M
7	Examin		4e. Fecility Name (If not institution	give street and nu	mber)		4b. City,	Town, or Loca				County of Death	
	<i>\$</i> -		Montgomery				(4.11- 3-	Olney		1		10NTGOM	
	Funeral		5. Social Security Number 579-01-7556	6. Sex 1XXM 2□ F	7. Age (In yrs. I. 94	ast birthday) Yrs.	Months	1 Year If U	urs Min.	8. Date of Birt (Month, Day Aug. 9	Year)	9. Birthi Coul M.a.	olace (State or Foreign ntry) .ryland
	Director		Usual Residence of Decedent		74					Aug. J	, 100	) J Ma	ryrana
	yland yow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mar B-1 st	tor	MD Fred	erick			Fred	erick					1 ☐ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number	3 Da 3			10f. Zip				10g. Citiz	zen of What Cou	ntry?
	ath w	rai	3545 Hopela					2170				U.S.A	
	er de	nue	11. Marital Status	Armed Fo		S. 13.	Was Dece	dent of Hispani cify Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)	1	<ol> <li>Race - America</li> <li>Black, White,</li> </ol>	
5	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced	ed 1X Yes If Yes, Gr Year or D	ve 42	-45	1 🗆 Yes	2√2 No Spe	ecity:			Specity: Bl	ack
5	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ted	15. Decedent	's Education		16a. Dece	dent's Usua	al Occupation		. 1	16b. Kir	nd of Business/In	dustry
2	hin 7	pie	(Specify only highes Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	kind of wo DO NOT u	rk done during se retired)	most of work	ring			
V	ad wit	Con	4th	16		Boi	ler			e Tech			ernment
2	be file tat Hy d oth event	Be	17. Father's Name (First, Middle, I		-a L					e (First, Middle,		Sumame)	
2	ould Men Men Men Men Men Men Men Men Men	우	Willis F.							e Morr		T	2 11
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Deparament of Health and Mental Hygiene.  Important: if liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		19a. Informant's Name/Relationsh Stephanie An		Grand	19b. Mailir						Town, State, Zip	
ນົ	1 and Healt tem 2		20a. Method of Disposition	der son		lace of Dispo	sition (Nar	ne of		Date	20c. Loc	ederick cation - City or To	own, State
5	ont of or of		1 Surial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp			emetery, crer Od a HO		ther place) emetej	ry 1.	/29/04			ring, MD
	artme ortar injur		21. Signatura of meral Service I	- 6 1 H		//			_				OME, P.A.
ŏ	Per Imp		+ souge	K. D.	now	Cla 2	46 N	. Wasl	n. St	., Rocl	kvil	lle, MD	20850
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death	. Do not ent	er the mod	e of dying, suc	h as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			epsis							Onset and Death Days
	/Medical Examiner		resulting in death)	Due to	(or as a consequ								Days
	LXAIIIIIICI		Sequentially list conditions,	b									
٦	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	ienca or							
	al-trai	xar	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of):							
00,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	call		d									
0	tificat og phy as th										1	1	
2	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregnation		∃Ectopic pr	egnancy			2	3d. Date of delive	
	e dea the at	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of de		Other (sp					Month	Day Year
	uires that the death certific signed by the attending p d be detached for use as		Part II. Other significant conditio	Re contributing to d	eath but not recu	ulting in the u	ndarhina c	ausa awan in E	Part I	23e Did to	bacco us	se contribute to ti	ne cause of death?
ń	signe	l by				interior in this di	ildəriyirig c	@030 g(+6)( II) (	art i.		_		pably 4 Unknown
corus,	w requir been si should	etec	Acute Rena	T EGTIN	<u> </u>					24a. Was		24h Wasa auto	psy findings available
ב	ne fav has ge 2	Completed								autop perfor	sy med?	prior to co death?	mpletion of cause of
NII A	Physician: The far this certificate has ral director, page 2	e Co	25. Was case referred to medical					26.1	Place of Door	1 Yes		1 🗆 Yes	2□ No
>	s cert	O B	examiner? 1 ☐ Yes 2∑ No	Hospital:	Inpatient 2 1	ER/Outpatier	t 3□ DC	Othor				☐Other (Specif	iv)
5	g Phy er the	n: T	27. Manner of Death	28a. Date		28b. Time of		8c. Injury at Work?		28d. Describe h			,
	Attending F death. ctor: After y the funera	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	ation	in, buy rour,	injury	М	1 🗆 Yes	2 🗆 No				
ž	or Attending ifter death. Diractor: Afte in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286 Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory	, office		28f. Location (S City or Tow	treet and n, State)	d Number or Rura	il Route Number,
ב	To the Hospital or Attendit within 24 hours after death. ** To the Funaral Director: A completely filled in by the fu		00.0.4%	- Di									
	the Hospital hin 24 hours a the Funaral I hpletely filled	edical	29a. Certifier 1 To Certifying (Check only 2 Medical I	g Physician: To the Examiner: On the b and man	i best of my knov asis of examinat ner stated.	wledge, death ion and/or in	n occurred vestigation	at the time, da , in my opinion	te and place, , death occur	and due to the o red at the time, o	ause(s) a late and	and manner as s place, and due to	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11			290	. License num	ber	2		signed (Month,	**
	J.		/ Alah Ill	41-1	hysician			D005	5694		Ja	an. 22,	2004
	T		30. Name and address of person of	who completed caus	se of death (Item	23а) (Туре,	Print)			_			
			Alok Mathur,						lle R	d., Oli	ney,	, MD 20	832
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signat	ture A	Sou	als					
	Registr	ar	JAW & O	LUUT /4	,	/-	17	-					

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of		Mental Hygie	_	04109
	Physici	an	Decedent's Name (First, Middle, Las	1	NIAT DCON			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give				or Location of Death		25 2004 4c. County of Death	
	Funeral Director		East Point Rehab. 5. Social Security Number 6. Security Number		center ge (In yrs. last birthday 49 Yrs.		Itimore   If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Dec. 25,	Balti 9. Birth Cou 1954 Mary	place (State or Foreign
	aryland show	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or t	_				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the M 3a or 28e-f	Direc	Maryland Harfo 10e. Street and Number 800 Conesteo Street			Havre de 10f. Zip Code 21	e Grace 078	10g	. Citizen of What Cou USA	
936	be filed within 72 hours after death with the Maryland all Hygiene. did Hygiene. did thygiene of other than "natural", or items 23a or 28e-f show other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puerto	becify Yes or No- Brican, etc.)	14. Race - Ameri Black, White, Specify: Bla	, etc.
Maryland 21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	16e. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retired tence Mec	during most of work d)	sing 161	b. Kind of Business/In Pipe Manu	
land 2	ould be filed withi Mental Hygiene. arked other thar atic event, the M	To Be Co	17. Father's Name (First, Middle, Last)  Jack Donaldson, 6	Jr.			18. Mother's Nam	e (First, Middle, Mai Cordelia	iden Sumame)	raccure
	d 2 shouth and h		19a. Informant's Name/Relationship (T Jacqueline Haines				and Number or Rui	ral Route Number, C	tity or Town, State, Zip	
Baltimore,	8 5		20a. Method of Disposition  19 Burial 2 Cremation 3 Companies 5 Other (Specify)		1 .	osition (Name of omatory or other place es United	ce)		c. Location - City or To avre de Gr	
Balt	permit. Page Department of Importent: If any injury of		21. Signature of Funeral Service Licens	cott	li li	552 Lewis	tt Funera s Street,	l Home, P Havre de	Grace, MD	21078
	/Medical Examiner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to minimediate	a. ACQUIE Due to (or as	ne.			SYNDR		Approximate Interval Between Onset and Death
68760, 🕾	icate be executed physician end s the burial-transit	dical Examine	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
P.O. Box (	that the death certifics ad by the attending ph deteched for use as t	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of delive Month	ery Day Year
	w requires that the been signed by th should be deteche		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the 2 No 3 □ Prob	he cause of death? pably 4 □Unknown
al Reco	The law ete has t page 2 s	Completed						24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		at 3 DOA Oth		h (Check only one)		
Division of Vital Records,	Jing After fune	atlon; To	1 Yes 2 100  27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28a. Date of Inju	ry 28b. Time	of 28c. Injur	y at	28d. Describe how i	e 6 □Other (Specifinjury occurred	v)
Divis	in Plate	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, et				City or Town, S.		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check-only one) 1	sician: To the best iner: On the basis of and manner sta	of my knowledge, dea f examination and/or i ated.	th occurred at the tin nvestigation, in my o	pinion, deeth occur	red at the time, date	e(s) and manner as si and place, and due to Date signed (Month,	o the cause(s)
	T V S		290. Striatore and title of certifier							
	341		30. Name and address of person who co	- 4	eath (Item 23a) (Type	Print)	R NV. 1	20. RA	HOMORE	, MD
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 9 2	1	ar's Signature					, '/

			1 - For State Registrar	State of Maryland		ment of Ficate of	Death	Reg.		4 O4 11
Ĭ	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last  Frances Mar  4a. Facility Name (If not institution, give,  Chester River Ho	v Demby	44	ches:	1.	January	Day Year  23, 200, 4c. County of Dear  Ken7	th
	Funeral Director		5. Social Security Number 6. Se 214–32–1549  Usual Residence of Decedent	7. Age (In yrs. Ia		Under 1 Year onths Days	Hours Min. 0	B. Date of Birth Month, Day, Ye 11/22/192	ar) 9. Biri	thplace (State or Foreign ountry) yland
	th the Marylan or 28a-f show e notified at	Director	10a. State 10b. County  Maryland Queen An: 10e. Street and Number		Town or Location			10g.	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No x
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is merked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, the Medical Examitrate usat be multified at	by Funeral Directo	219 Pine Tree Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X	If Ye	21620 Decedent of H s, specify Cuba Yes 25 No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:		14. Race - Ame Black, Whit	
21215-0036	within 72 hour lene. Than "natural he Medical Ex	Completed t	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent (Give kind life. DO I	of work done on NOT use retired	during most of working		! . Kind of Business/	Industry
Maryland 2	should be filed ind Mental Hygid s marked other umatic evant, II	To Be Co	17. Father's Name (First, Middle, Last) Herman W. Elliott  19a. Informant's Name/Relationship (Ty	(ne Print)			18. Mother's Name (in Mary Addional Add	First, Middle, Maid e Cooper		
	Pages 1 and 2 sho nent of Health and int: If itam 27 is m iry or other traum		Elsie B. Brown/ Date 20a. Method of Disposition 1 Burial 2 Ocemation 3 OF	lghter 20b. Pia	3934 Geo	orgetown n (Name of ny or other place	n Road, Che	estertown	Location - City or	1620 Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		* 4 Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	99	Fell	me and Addres	elfenbein a	& Newnam	Funeral	Home, P.A.
	/Medical Examiner	Examiner	23a Fart1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. A CUTE YOU  Due to (or as a conseque	YUCAN  Y AN	DIM		TION	<i>ycon</i> , 13.	proximate Interval Between Onset and Death 30 min cr
Box 68760,	leath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Ex	in the past 12 months?	Due to (or as a conseque d	eath 3⊟Ecto	pic pregnancy			23d. Date of deli	very Day Year
rds, P.O.	es that the d igned by the be detached	þ	1 ☐ Yes 2 (No 9 ☐ Unknown  Part II. Other significant conditions cor	9□ Unknown		er (specify)	en in Part I.		1	the cause of death?
		<b>Completed</b>	DIABETES ME  25. Was case referred to medical	LITUS				24a. Was an autopsy performed?	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
Division of Vil	itending Physicath. tor: After this the funeral di	Certification; To Be	examiner?	1	8b. Time of Injury		at 28c ?? ∕es 2 □ No	5 Residence	ury occurred and Number or Rui	
_	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edical	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occ n and/or investig	ation, in my op	inion, death occurred	at the time, date a	nd place, and due	to the cause(s)
l	viil To Con	Σ	29b. Signature and title of certifier  30. Name and address of person who co	moleted cause of death (feet C	3a) (Tuna Brich	-	1041587		ate signed (Month,	Dey, Year)
	Sta		Helen A. Noble, 12  31. Date filed (Month, Day Alpar) 2 8		Chester		Maryland 21	620	ř	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** JUSEPHINE ANHARY 22 2664 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Poromac CARE POTOMAC MONTGOMERY MANOR If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖾 F 92 Yrs. Virgínia Director Oct. 6, 121-03-7268 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. Internst of Health and marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7305 Brookstone Ct. 20854 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Black Completed by Specify: 3 ☑ Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) New York City Elementery/Secondary (0-12) College (1-4or 5+) 5+ Social Worker Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cotilia Robert Crocker Johnson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Caswell Evans / Son 7305 Brookstone Ct., Potomac, MD 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 24 injury or Chesapeake Crematory, Inc. 2004 Beltsville, MD 22. Name and Address of Fecility
Rapp Funeral & Cremation Services 21 Signature of Funeral Service Licenses 933 Gist Ave., Silver Spring, MD 20910 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) 2 Weeks Asperation Pneumonia Examiner Due to (or as a consequence of) Physician/Medical Examiner Cerebrovascular Accident 01d or Attending Physician: The law requires thet the death certificate be executed use es the buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Atherosclerosis 01dDue to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Advanced Dementia Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? TILY YES 27 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. edical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D31319 January 23, 2004 3 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 8218 Wisconsin Ave., #305; Bethesda, MD Loreto S. Albiol, M.D.; 20814 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State **JAN 28** 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Month Year **Physician** 00: 40 M ROSETTA EL-ZEIN 28 POOL anuarn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 【XF Director 208-66-0742 45 LÍBERIA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo MD. MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23s or items and it items 27 is marked other than "natural; or Items 23s or items in an item in a marked other than a natural; or Items 23s or items in a natural items in a natural items. 404 BLUE SILK LA. #K 20879 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 XNo fYes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SALES PERSON CAR MAX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SMITH ဂ ALFRED ANNIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HASSAN EL-ZEIN/HUSBAND 404 BLUE SILK LA. #K, GAITHERSBURG, MD. 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEM. 2-2-2004 SILVER SPRING, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral Hemorrhage inknowy /Medical Due to (or as a consequence of) **Examiner** unknown Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of) Examine The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical attending I for use as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 **X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 - Inpatient ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mistin Harlan Howe MB D0059871 January 28, 2004 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, Mayland 20852 Chiston Parky Howemo 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 Darks Registrar

			l State		yland / Depa	rtment of H			ene_200	4 04 1 1 3
		,	Registrar AMEND#9per INF2/  1. Decedent's Name (First, Middle, Last)	4/04,69W,MC	0			2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic	al	7	l, Jr.				January	18, 2004	9:58 A. M
	Examin		4a. Facility Name (If not institution, give stre 5411 Albemarle St			4b. City, Town, o Bethe	r Location of Death sda			gomery
	Funeral Director		5. Social Security Number 6. Sex 1 № N		In yrs. last birthday) 80 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Jan. 18,	1924 <del>-</del>	Birthplace (State or Foreign Country) S. Carolana
	0		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Los	cation				10d. Inside City Limits
	shov	ō	Maryland Montgomen		Bethe					1 ☐ Yes 2 No
,	28a-1	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	t Country?
	N WITH		5411 Albemarle Str	reet		208			U.S.A.	
30	be filed within 72 hours atter death with the Maryland Hygiene. Hygiene. d other than "natural", or Itams 23s or 28s-f show event, the Madicial Exercities must be notified at	by Funeral	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	. Was Decedent Ev Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: J	June 1943_	Vas Decedent of H f Yes, specify Cubi I ☐ Yes 2🂢 No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. Thite
9500-617	72 hou natura		15. Decedent's Educa (Specify only highest grade of	tion	16a Deced	lent's Usual Occup kind of work done	pation during most of work d)	ing 1	6b. Kind of Busine	ess/industry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			<sub>d)</sub> Executiv		Investm	ents
N	filed withi Hygiene. other than	e Co	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Sumame)	
<u>a</u>	should be find Mental finarked of	To B	John Efird				Esthe			
	es 1 and 2 should b of Health and Ment if item 27 is marked ir other traumatice		19a. Informant's Name/Relationship (Type				and Number or Rur			
	l and Health He 27 ther tr	1	Sarah Efird/ Daught  20a, Method of Disposition	ter	20b. Place of Dispo cemetery, cren		Le St., Be		0c. Location - City	
5	Pages nent of hant: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cometery, cren Arlington		1 1 1 0 0	/2004	Atlanta,	Georgia
Baltimore,	permit. Pages 1 Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee	luch	22	. Name and Addre	onsin Ave			
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final	cause on each line	ne death. Do not ent			or respiratory arre	st,	Approximate Interval Between Onset and Death Years
1	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):					Voores
ŝ	Examiner	<u>_</u>	Sequentially list conditions, b.		clerotic \ consequence of):	ascular	Disease			Years
	nted f insit	Examine	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Hyperte						Years
ó	cate be executed oblysician and the burial-transit		resulting in death) Last		consequence of):					
8760,	ate be physicia the bu	dical	d.							
.O. Box 6	ath certifications in the state of the state	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnanc Other (specify)	ey .		23d. Date of Month	f delivery Day Year
<u>α</u>	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions control	ributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.			te to the cause of death?
of Vital Records,	The law requir te has been si age 2 should I	Completed						24a. Was ar autops perform 1 Yes 2	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
ital		Be C	25. Was case referred to medical examiner?			- 15		th (Check only one	9)	
<u>ح</u>	Physician: The this certificate har all director, page	ုင	1 ☐ Yes 2 🛣 No Ho	ospital: 1 ☐ Inpatien		11 3LI DOA		ome 5 X Reside 28d. Describe ho		(Specify)
on	ding P. h. After funeri	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	Wo	ork? ]Yes 2 ☐No		,	
Division	I or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, sti (Specify)	reet, factory, office		28f. Location (Str. City or Town	reet and Number o , State)	or Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	Medical Co	29a. Certifier Chack only one) Certifying Physical Examin-	cian: To the best of er: On the basis of and manner stat	examination and/or in	h occurred at the t vestigation, in my	time, date and place, opinion, death occur	, and due to the ca rred at the time, da	use(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the within to the comple	Me	29b. Signature and title of certifie	1/////		29c. Licen	ise number	29	d. Date signed (A	
)	25		1 Lamer	V. Ye	wy	2599	92		January	20, 2004
			30. Name and address of person who con Daniel V. Young, M.	1.D. 45/30	ath (Nem 23a) (Type, ) Connecti	cut Ave.	, NW, Was	hington,	DC 2000	08
7	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Spark	2			

			1 - For State Registrar	State of Marylar		artmen rtificate				Reg. N	4 U U I	04115
i	Physici		1. Decedent's Name (First, Middle, Last) HORACE ED	WARDS, Jr					2. Date o Month JAN	Da	2004	3. Time of Death 9:45 A
	/Medio		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or i	Location of D			c. County of De	
			Shady Grove Adv	entist Hosp	pital		Rock	vill.	e _		MONTGO	OMERY
40	Funeral		5. Social Security Number 6. Sex			If Under Months	1 Year Days	If Under 24 Hours	Vin. (Month	Birth Day, Year	9. B	irthplace (State or Foreign Country)
	Director		422-70-7447	M 2 49	Yrs.				Mar	8,19		labama
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Maryl 4 sho	ō	MD Montgom	ery	Gaith	nersb	ura					1⊠Yes 2⊡-No
	128s	rec	10e. Street and Number			10f. Zip				10g. C	itizen of What C	Country?
	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show he Mudical Exaction most be notified at	<b>Funeral Director</b>	10334 Royal N	Woods Ct.			20	0886			U.S.A	•
	deat ems	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Deced	ent of His	panic Origin Mexican, P	? (Specify Yes of uerto Rican, etc.	No-	14. Race - Arr Black, Wh	
36	or le	y Fu	1 XNever Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give	i	1 ☐ Yes 2		Specify:		,		Black
21215-0036	hours	ed by	3 Widowed 4 Divorced	Year or Dates:	162 Door	dont's Heur	I Occupat	tion		165	Kind of Busines	
7	in 72	iete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usua kind of wor DO NOT us	k done du	ıring most of	working		berts-	•
12	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  3 yrs		Cler						son & Co.
פַ	Hyg other	BeC	17. Father's Name (First, Middle, Last)	3 3 2 3				18. Mother's	Name (First, Mi	ddle, Maide	n Sumame)	
lar	Alenta Alenta rked ritc sv	To B	Horace Edward	ds, Sr.				Ge	ertha 3	Jemis	on	
Maryland	and Name		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ing Address	(Street ar	nd Number o	r Rural Route Ni	ımber, City	or Town, State,	Zip Code)
≥ .	and ealth m 27			(Son)				awn I	Dr. Col			
Baltimore,	H ite		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Re	amous from State	Place of Dispo cemetery, crea	matory or or	ther place		Date		_ocation - City o	
ij	t. Pa		'4 □Donation 5 □ Other (Specify)	-	.1 Sou							own, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-1 show say injudy of other traumatic svent, the Medical Exaction may be a called all once.		21. Signature of Funeral Service Ucers	Thouse								HOME, P.A. MD 20850
*:			23a. Part1. Enter the disease, or complice shock, or heart/failure. List only on	eations that caused the dea	th. Did not en	ter the mode	e of dying	, such as car	diac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Pinal disease or condition	Cere	bral	Infa	rcti	on				11 days
73	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							1
ķ.		5	Sequentially list conditions, b	Due to for as a consider	guence of							
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immovate cause. Enter Underlying Cause (Disease or injury	,								
Ć	te be executed ysicien and e burial-transit		that initiated events c resulting in death) Last	Due to (or as a consec	quence of):							
1760,		cal		l								
89		Med	IF FEMALE:									
Вох	ath ce ttendi	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death 3[	⊒Ectopic pre					23d. Date of de Month	elivery Day Year
0.		Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of a 9□Unknown	death 5	Other (sp	ecify)			-		
٥.	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as	P	Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	underlying ca	ause giver	n in Part I.	239. [	oid tobacco	use contribute	To the cause of death?
Vital Records,	uires tha signed I d be det	d by	Heart Trai		•	, ,	3			☐ Yes 2	2 □ No 3 □ F	Probably 45Unknown
200	v requir	Completed							24a \	Was an	24h Were a	autopsy findings available
Re	The lavate has	E D							—   a	utopsy erformed?	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical					26 Place of	1 ☐ Y	es 212 N	o l 1∐Ye	s 2 No
>		o B	avaminer?	ospital: 1 🔀 Inpatient 2	ER/Outpatie	nt 3[] DO			ng Home 5 [		6 ∏Other (Sp	ecify)
of		n:T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		8c. Injury	at			ury occurred	,
ior	Attending I r death. ector: After by the funer	atlo	1 X Natural 5 ☐ Pending investigation	(Month, Day 1 Bal)	injuty	М		es 2□No				
Division	of or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory	, office			on (Street a Town, Stat		Rural Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by ti	edical C	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred anvestigation,	at the time in my opi	a, date and p nion, death o	lace, and due to	the cause(s me, date ar	s) and manner and place, and du	as stated. ue to the cause(s)
	Fo the	Me	29b. Signature and title of certifier			29c	. License	number		29d. D.	ate signed (Mor	nth, Day, Year)
)			> Day		-M	) :	D586	81		Ja	n. 21,	2004
	1		30. Name and address of person who co						D		· · · · · · · · · · · · · · · · · · ·	
			Jude Alexande			alca	т Се	enter	υr., F	CCKV	ттте,	MD 20850
4	Sta Regist		31. Data filed (Month, Pay, Year)	32. Registrar's Sign	/.	10	-	·				

Ralph Ford 04-00450 RJ

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

sici		1 - For Amended Item#1 State Unpended Item#23 Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Dear		
ledic		RALPH MIC	CHAEL FO	ORD	JR		January	Day Year 16, 2004	1251 P		
mir		4a. Facility Name (If not institution, give s	treet and number)			r Location of Deat	h	4c. County of Dea			
		Peninsula Regiona  5. Social Security Number 6. Sex		enter i. last birthday)	Salisk	oury  If Under 24 Hrs.	R Date of Righ	Wicomic			
eral			M 2□F 68	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y March 28,19	935 Vi	thplace (State or For ountry) rginia		
3		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Lin		
	Director	Maryland Wicomico	) Ma	ardela	Springs				1 ☐ Yes 2 <b>∑</b>		
UNIT OR DESIGNATION AND	Dire	10e. Street and Number 23505 Old Bradley I	ьд		10f. Zip Code 2183	7	10g	. Citizen of What C	ountry?		
	Funeral		2. Was Decedent Ever in	U.S. 13.			pecify Yes or No-	USA 14. Race - Am	erican Indian.		
Examinar	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: AirF		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		o Rićan, etc.)	Black, Whi	te, etc. white		
any injury or other traumatic event. The Mudical Exp once.	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of wor	rking 16	b. Kind of Business	/Industry		
e Me	Ig m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)					
D.	ပို	12 17. Father's Name (First, Middle, Last)		CPA		18. Mother's Nar	ne (First, Middle, Ma	Accountin	<del>g</del>		
i c	To Be	Ralph Michael Ford	Sr.				eth Chris	,	luoll		
n n	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street		ural Route Number, C				
ser tra		Helena A. Ford/wife				33A, Del	mar, DE 19				
0 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, cre-	osition (Name of matory or other place			c. Location - City or	Town, State		
dury		'4 □Donation 5 □ Other (Specify)					1/21/04	Hurloc			
any ii		1. Sunature of Funeral Service License		SP	HOLLOWay	Funeral	Home Profe , Salisbur	essional	Associatio		
	cal Exan iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  b.  Use to (or as a consequence of):  C.  Due to (or as a consequence of):									
ğ e				fate nancy				23d. Date of de	livery		
lor use as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)	<b>,</b>		Month	Day Year		
oe detached for use as t	ed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[ death 5[	Other (specify)			cco use contribute t	Day Year o the cause of death		
detached for use as t	ompleted by	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[ death 5[	Other (specify)			2 No 3 P	Day Year o the cause of death robably 4 Unkni		
, page 2 should be detached for use as t	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner?	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown  tributing to death but not re	tal death 3[ death 5[	Other (specify)	en in Part I.  26. Place of Dec	1 ☐ Yes 24a. Was an autopsy penforme	2 No 3 P	Day Year of the cause of death robably 4 Unknown utopsy findings avail completion of cause		
al director, page 2 should be detached for use as t	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1   Natural   5   Pending	1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown tributing to death but not re	tal death 3[ death 5[	Other (specify)	en in Part I.  26. Place of Dealer: 4 \( \text{ Nursing Fig. 1} \)	1 Yes  24a. Was an autopsy performe 1 Yes 2	2 No 3 P  24b. Were a prior to death? No 1 Perior to death?	Day Year of the cause of death robably 4  Unknown utopsy findings avail completion of cause s 2  No		
ne funeral director, page 2 should be delached for use as t	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown  tributing to death but not re	al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 dea	Other (specify)  Inderlying cause give  and 3 DOA Other  28c. Injur  Wor  M 1	en in Part I.  26. Place of De: er: 4 □ Nursing F	24a. Was an autopsy performe 1 Lyes 2 Lath (Check only one) dome 5 Lasidence 28d. Describe how	2 No 3 P  24b. Were a prior to death? No 1 Yes  26 Other (Speinjury occurred	Day Year of the cause of death robably 4  Unknow utopsy findings availation of cause s 2  No		
ne funeral director, page 2 should be delached for use as t	edical Certiflcation: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions con    25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1   Natural   5   Pending investigation   3   Suicide   6   Could not be determined    29a. Certifier   1   Certifying Physical Phys	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown  tributing to death but not re  ospital: 1 Inpatient 2[ 28a. Date of Injury (Month, Day Year)	Lal death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 de	Other (specify)  Inderlying cause give  Int 3 DOA Other  28c. Injur  Wor M 1  reet, factory, office	en in Part I.  26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No	24a. Was an autopsy performe 1 Ves 2 ath (Check only one) dome 5 Resident 28d. Describe how 28f. Location (Stree City or Town, 3	2 No 3 P  24b. Were a prior to death? 1 No 1 Yes  26 6 Other (Speinjury occurred  at and Number or R  State)  se(s) and manner a	Day Year  of the cause of death robably 4  Unknown utopsy findings availation of cause at 2 No early)  ural Route Number, as stated.		
funeral director, page 2 should be detached for use as t	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner?  1   Yes   2   No	1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown  tributing to death but not re  cospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Specials)  ician: To the best of my kner: On the basis of examinand manner stated.	Let death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 de	Other (specify)  Inderlying cause given the second of the	26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No me, date and place pinion, death occu	24a. Was an autopsy performe 1 Yes 2 ath (Check only one) tome 5 Resident 28d. Describe how 28f. Location (Stree City or Town, 3 and due to the causured at the time, date 29d	2 No 3 P  24b. Were a prior to death? 1 Yes  26 6 Other (Speinjury occurred  at and Number or R  Sa(s) and manner a pand place, and due.  Date signed (Mon.)  January 1	Day Year  of the cause of death robably 4  Unknown utopsy findings avail completion of cause is 2  No  polify)  ural Route Number, is stated, is to the cause(s)  th, Day, Year)  7, 2004		

# Ahonda Genean Frazier Baltimore, Maryland 21215-0036

Box 68760,	
ds, P.O. B	
Vital Recor	
Division of	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:55PM RONDA GENEAN FRAZIER 27 2004 ANWARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Doctors Community Hospital Lanham if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖫 F Yrs 1970 Washington, D.C. 577-13-1953 Director 33 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural; or tlems 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be recibled at once. 10a. State 10b. County 1 ☐ Yes 2 XNo Director Springdale MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3411 St. John's Place 20744 U.S.A Funerai 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Black Specify. Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Event Tickets Sales Manager 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Arlene Thompson James Solomon Frazier ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14803 Lee Highway, Gainesville, Va. 20155 Grace T. Smith (Aunt) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 □ Cremation 3 □ Removal from State Pleasant Valley 4 ☐ Donation 5 ☐ Other (Specify) 01/31/2004 Annandale, Va. Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Ames Funeral Home, Inc. 8914 Quarry Rd. Manassas, Va. 20110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner averal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a/cg certificate be Physician/Medical 88 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 12 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 Yes 2 No 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 To No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide To the Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier baduna) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MODUPE HANOVER PKWY GREENBELI 7325A OBADINA

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 0 2004

32. Registrar's Signature

		For State Registrar			Cei	tifica	te of L	Death			Reg. No.		UHIII
iois		Decedent's Name (First, Middle, Las.	t)							<ol><li>Date of De Month</li></ol>	ath Day	Yeer	3. Time of Death
sicia ledic		MYRNA			F	RANK				JANUAR			2:00 A
min		4a. Facility Name (If not institution, give	street and number	ər)		4b. City		Location o			4c.	County of Deat	th
		SUBURBAN HOSPITAI						THESD					TGOMERY
eral		Social Security Number     6. Se	x 7. □M 2√∏F	Age (In yrs.	last birthday)	If Unde Months	Days	If Under:	Min.	8. Date of Bit (Month, Da	th ay, Year)	9. Birt	hplece (State or Foreignuntry)
tor		5//-52-5326	- W - X-	. 6	6 Yrs.					07/21/	1937	NEW	YORK
5	}	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	tv. Town or Lo	cation							10d. Inside City Limits
dulingity evelt, in the property in the state of the stat	5		227	CTIT	ZED CDD	TNO							1 ☐ Yes 2√ No
	Director	MARYLAND MONTGOMEI	XY	PITI	ER SPR	_	p Code				10a Citi	zen of What Co	21
	급			- "-7.0							-		, ditty .
	Funeral	3200 N. LEISURE WO	ORLD BLVI 12. Was Decede			209		spanic Orig	gin? (Spe	city Vas or N	U.S.	A • 14. Race - Ame	nican Indian
	un I	11. Marital Status	Armed Force 1 [ Yes 2]	s?	7.3.	f Yes, sp	ecify Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	
	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 🗆 Yes	2X) No	Specify:				Specify: WH	ITE
	pe	15. Decedent's Ed		· · · · · · · · · · · · · · · · · · ·	16a. Dece	dent's Us	ual Occupa	ation			16b. Ki	nd of Business/	
	Completed	(Specify only highest grad	de completed)		(Give	kind of w	ork done d	furing mos	t of worki	ng	100.10		mastry .
	Ē	Elementary/Secondary (0-12)	College (1-4	or 5+)	EXECUT						II. S	. GOVER	NMENT
		17. Father's Name (First, Middle, Last)			EXECUI	LVE	DLOIL		r's Name	(First, Middle			
	Be		CT	T 1712 D C 11	PETM			HARR					SHAFT
	ဥ	PAUL  19a. Informant's Name/Relationship (7		LVERST		a Addroi	c (Street			J Poute Numb	or City o		Zip Code) 20906
					3								SPRING, M
d		MARVIN FRANKLIN/H  20a. Method of Disposition	USBAND	20h. I	Place of Dispo			KE WO		ate		cation - City or	
		1 KBurial 2 ☐ Cremation 3 ☐	Removal from Sta	(	cemetery, crei	natory or	other plac						
١		`4 □Donation 5 □ Other (Specify	)	KIN				-	-				H, VIRGINIA
OUCE		21. Signature of Funeral Service Licen	see /		$D^{22}$	Name a NZAN	nd Addres	s of Facilit FOLDB	ERG 1	MEMORIA	L CH	APELS,	INC.
		1 (manda )	rdewice	7_	11	.70 R	OCKV.	ILLE :	PIKE	, ROCK	/ILLE	, MD 20	0852
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that cau	sed the dea	th. Do not ent	er the mo	de of dyin	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between
2		Immediate Cause (Final disease or condition	aMETASTA										Onset and Death 4 YEARS
		resulting in death)	u	as a consec		JAIN OL	111						
			_										
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	quence of):								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
	Еха	resulting in death) Last	Due to (or	as a consec	quence of):				-				
ĺ	cai		d										
			-										
	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			75						23d. Date of del	livery
	cia	in the past 12 months? 1 ☐ Yes 2 🏵 No	1□Live birth 4□Pregnan	t at time of o		JEctopic   ] Other (:	oregnancy specify)					Month	Day Year
	ysi	9 Unknown	9□ Unknow	n									
	by Physician/Medi	Part II. Other significant conditions of	ontributing to deat	h but not re	sulting in the u	nderlying	cause give	en in Part I		23e. Did	tobacco u	ise contribute to	the cause of death?
	q p									1 🗆	Yes 27	∑No 3□Pr	robably 4 Dunknow
	Completed			,						24a. Wa:	200	24h Were at	utopsy findings available
	щ			<del>_</del>						auto	psy ormed?	prior to death?	completion of cause of
	ပိ									1 Yes	2 💢 No	1 🗆 Yes	2 □ No
	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Death	(Check only	one)		<del></del>
	2	1 ☐ Yes 2 🖾 No	to the same of the		ER/Outpatier		-	40140	-		_	6 ☐Other (Spe	cify)
	.uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		28c. Injun Worl	k?		28d. Describe	how injur	y occurred	
	Certification;	2 Accident investigation				М	10	Yes 2□	-				
	ţ	3 Suicide 6 Could not be determined	288. Place 0	Injury - At h , etc. (Speci	nome, farm, st. ify)	reet, facto	ry, office			28f. Location City or To			ural Route Number,
	Cer												
	cai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exan											
	edical	one)	and manne		ation and or in	vostigatio	, it itiy o	pintori, dda					
	ž	29b. Signature and title of certifier	1 /1			2	9c. Licens	e number			29d. Dat	te signed (Mont	h, Day, Year)
	II	7/1	1000	an	MD	D.	22775				JANU	ARY 27,	2004
	1												
		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type.			-					
completely tilled in by the luneral director, page 2		30. Name and address of person who FREDERTCK G. BAR! 31. Date filed (Month, Day, Year)				Print)		-	ту сн				

	•	For State Registrar	State of Maryla	nd / De	partme		Mental Hy	_	004 0411
Physiciai /Medica	n al	Decedent's Name (First, Middle, La     CATHERINE  V  4a. Facility Name (If not institution, give	'ICTORIA F	RALEY	4b Cin	r, Town, or Location of De		Day 26	Yeer 3. Time of Death
Examine Funeral Director		Fahrney-K 5. Social Security Number 6. S	eed Wursin		e Bo	onsbor	Irs. 8. Date of Bir	(Uci Si	9. Birthplace (State or Foreig Virginia
e Maryland 8e-f show	ctor	Md. Washir		Dity, Town or Boor	Location ISboro				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with th	Funeral Director	9121 Crystal Fa	lls Drive		10f. Z	ip Code 21713		10g. Citizen of W United	what Country? I States
		11. Marital Status  1 Never Married 2 Married  3 Nover 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 1:	3. Was Dec If Yes, sp 1  Yes	edent of Hispanic Origin? ecity Cuban, Mexican, Pu 22/No Specity:	(Specify Yes or No erto Rican, etc.)		e - American Indian, k, White, etc. : White
thin 72 ho e. en "netu Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dei (Gi	cedent's Us ve kind of w DO NOT	ual Occupation ork done during most of v use retired)	vorking	16b. Kind of Bu	siness/Industry
filed within Hygiene. ther then " int, the Mei	5	8	0	F	lomema				Home
I be fill he ded out	Be	17. Father's Name (First, Middle, Last William F. Cu	llers			18. Mother's N	lame <i>(First, Middl</i> e 1 ino Sn	, <i>Maiden Sumam</i> Lyder	9)
should nd Men marke amatic	9	19a. Informant's Name/Relationship (		19b. Ma	iling Addres	ss (Street and Number or			State, Zip Çode)
and 2 lealth a m 27 is her trau		Patricia A. Harge	tt/ daughter	9	121 C	rystal Falls	Drive,	Boons bor	o, Md. 21713
Pages 1 ment of H ant: # ite		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	Removal from State	Place of Dis cemetery, c	rematory or	other place)	/31/04		City or Town, State Id, Maryland
permit. Departr Importa any inj		21. Signature of Funeral Service Lice	N Barbe		Muri D O	ind Address of Facility el H. Barber Box 5038	Funeral	Home	d. 20882
buricia b	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a conse	equence of):  That equence of):	Hear th	J'estras			
igned by the attending physical periods of the delached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthed 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death	3 □Ectopic   5 □ Other (\$			23d. Date Mon	e of delivery hth Day Year
es that igned b	2	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying	cause given in Part I.			ibute to the cause of death?
been si should	eted	Justices /	Multa inf	ant	Llen	en la	-	Yes 2 □ No	
Attending Physicien: The law requires that the death certificate regent. setor: After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the	Completed						24a. Was auto perfo 1 Yes	psy prmed2 d	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
sician	9 Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:			Other	eath (Check only		
ding Physical After this funeral di	tion: To	27. Manner of Death  1 DNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time		28c. Injury at Work?  1 ☐ Yes 2 ☐ No	Home 5 ☐ Resi 28d. Describe	dence 6 LOthe	
in Direction	Certification:	2 Accident 3 Suicide 4 Homicide	One Pleas of Injury At	home, farm, city)			28f. Location ( City or To	Street and Numbe wn, State)	er or Rural Route Number,
Ne Hospital	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exe	nysicien: To the best of my ki miner: On the basis of exami and manner stated.	nowledge, de nation and/or	ath occurre investigatio	d at the time, date and plan, in my opinion, death oc	ace, and due to the courred at the time,	cause(s) and mar date and place, a	nner as stated, and due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and Mile of Certifier  Vanton	Jung			05. License number	2	Jan. a	37, 2004
		30. Name and address of person who Dr. Vincent Canto				, Boonsboro,	Maryland	1 21713	
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature &	10	aks			

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25 2004 1:37 A FOREMAN auvary ROBERT L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Pay, Year) NOV • 19 • 1933 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Maryland **Funeral** 1 XM 2 ☐ F 70 218-30-7608 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County Itams 23a or 28a-f show ntal Hygiene. Indicate than "natural", or Itams 23a or 28a-f show event, the Medical Examinal must be notified at Yes 2 No Clarksburg MD Montgomery Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20871 U.S.A. 23412 Stringtown Road Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after ☐Yes 2√2 No Yes, Give 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black 3 Widowed 4 Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Custodian 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever Helen Foreman John W. Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20871 19a. Informant's Name/Relationship (Type, Print) 23412 Stringtown Road, Clarksburg, MD ont of Health a Frances R. Foreman (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 1/31/04 Clarksburg, MD JOhn Wesley Cem 4 Donation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Funeral Service Licensee 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Sep515 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 500 mall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as the l for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting jugthe underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 3 DOA Medical Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No 1 24 hours after death.

10 Funeral Director: A pletely filled in by the fu death. 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2. 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANACES 31. Date filed (Month, Day, Year) 32. Registrar's Signature **JAN 28** 2004 autos Registrar

			State of Maryland / Dep		•	•	
			_ FOI	rtificate of Death	Rag.	_ ZUU4	, 04/22
	- · · ·		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		George Watson Fisher			24, 2004	6:35P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	F	•	Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday	Silver Spring  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Montgome 9. Bin	hplace (State or Foreign
	Funeral Director		717-09-9004 1™ 2□F 83 Yrs.	Months Days Hours Min.	Feb. 16,	1920 Pen	nsylvania
	D > 0		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of 1	ocation			10d. Inside City Limits
	l show	ō					1 ☐ Yes 2 No
	28a-	rect	Maryland Montgomery Silver S	10f. Zip Code	10g.	Citizen of What Co	untry?
	h with	<u>a</u>	3523 Twin Branches Drive	20906	U	nited Sta	ites
	deat ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Amed Forces? 13	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame Black, Whit	nican Indian,
36	or It	y Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No World	1 ☐ Yes 2 ☑ No Specify:	,	Specify:	
Ö	within 72 hours after death with the Maryland ane. then 'ratural', or Items 23a or 28a-f show the Medical Examinar must be notified at	ed b		edent's Usual Occupation	161	. Kind of Business	nite Industry
215	hin 72 an "ng Medik	plet	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing		,
21	ygiene /giene /er the	Соп	1 Admi	nistrative Assista		U.S. Cong	ress
pug	be fill Hall Hall Hall Hall hall oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
Maryland 21215-0036	hould d Mer marks matic	٥	Harry A. Fisher  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	Lrene ing Address (Street and Number or Rura	Rosenberg		Zin Code)
Ma	nd 2 s ulth an 27 is r trau			Twin Branches Dri			
ē,	itam itam		20a. Method of Disposition 20b. Place of Disposition completely, or	osition (Name of	Date 200	. Location - City or	
Ë	Page ment cant: If ant: If		L'remator	lum. Inc. 200	4 Be	thesda, M	laryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-1 show any joury or other traumatic evant, the Medical Examiner must be notified at once.		21. Signature of Fulleral Service Licentee	2. Name and Address of Facility Rob ockville, Inc. 300 ockville, Maryland	ert A. Pui West Mon	mphrey Fu	neral Home/
	0 D ≥ 6 0		23a. Part1. Enter the disease, or complications that caused the death. Do not en			805	Approximate
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Cardiogenic S  Due to (or as a consequence of):	nock			
	Examiner		Coronary Diag	ase			
	ti g	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transit	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):				
760,	ite be ex ysician ne burial	calE					
89	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit						
Box	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of del	
-	e dea the at	Physician/Med	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown	Other (specify)		Month	Day Year
P.0	uires that the de signed by the a Id be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	uires signa ild be	Completed by	Atrial Fibrillation		1 ☐ Yes	2 □ No 3 □ Pr	obably 4XIUnknown
Ö	aw requir s been si 2 should l	olete	Hypertension		24a. Was an	24b. Were au	topsy findings available
Re	sician: The law certificate has t irector, page 2 s	mo			autopsy performed 1 ☐ Yes 2Å	? death?	completion of cause of 2 No
/ital	ctor, p	BeC	25. Was case referred to medical examiner?		(Check only one)		
of √	Physicathis call dire	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie		me 5 ☐ Residence		cify)
on C	ding F h. After funer	tlon:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year)  Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how it	njury occurred	
Division of Vital	Attan r deatl sctor:	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Street		ıral Route Number,
Ö	s after al Dire	Certi	4 Homicide determined building, etc. (Specify)		City or Town, S	rate)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place, avestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	tha P	Medical	one) and manner stated.  29b. Signature and file of certifier	89c. License number		Date signed (Monti	
	2 # P 8   S + 1	_	* A Ludiuax QUIV	D74819	1	760	4
	) 24 F (		30. Name and address of person who completed cause of death (flem 23a) (Type	, Print)	4	2-10	
				eron Street, Silve	r Spring.	Maryland	20910
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spark			
	Registr	ar	JAN 2 9 2004 Server 5	July - Mary			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 26 3:15 рм WILLIAM DONALD FINN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 421 Hamlet Club Drive, #305 Anne Arundel Edgewater If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 159-22-6365 75 Director Mar. 11 1928 Pennsylvania Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Madical Examiner trust be notified at 1 Yes 2 No Md. Anne Arundel Edgewater Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 421 Hamlet Club Drive, #305 21037 United States or Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No tf Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced WWII "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Scientific Instrument Elementary/Secondary (0-12) Cottege (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 le marked other than eny injury or other traumatic event, the Mones. 12 Chemical Engineer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Finn Julia James Howard ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather A. Finn / Wife 421 Hamlet Club Drive, #305, Edgewater, Md. 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/30/04 Silver Spring, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven permit. <sup>22</sup> Name and Address of Edity Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee murie P. 0. Box 5038, Laytonsville, Md. 20882 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ovastatic Carcinouna Physician Tyears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the first lines from Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ iabetes icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed failure Leinal 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Jui 1/26/2004 Klo 20+1 Rd. #300 Annapolis, Web. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestraate Strant Selonich 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Jener Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26, 2004 JAN. 1:50 PM **Physician** WEI FANG HAN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital MONTGOMERY Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 27, 1913 9. Birthplace (State or Foreign Country)
China 6. Sex 5. Social Security Number **Funeral** Hours Days 1 □ M 2 🔀 F 031-54-3084 90 Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 SYes 2 No Director MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3509 Thornden Terrace 20817 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Completed by **Widowed 4** □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 4 yrs Housewife Home other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown L. Hsu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8509 Thornden Terrace, Bethesda, MD 20817 Dickson Fang (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Funeral Srv1-27-2004 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. lu 246 N. Wash. St., Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): SPILATION PNEUMONTA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The taw requires that the death certificate be executed signed by the attending physicien and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABOTES MELLINS, HYPORTENSION, 1 Yes 2 No 3 Probably 4 Unknown STATUS POST LINEBROVASCULAR ACCIDENT, 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? TOTAL CARE 2 No & No 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pendina Natural 1 Tes 2 No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tittle of certifier 26th, January, 2004 2 GATHERUSBURG, MD: LUSTS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DSID DARNESTOWN ROAD 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	9300
To the Hospitel or Attending Physicien: The	Fo the Funeral Director: After this certificate	completely filled in by the funeral director, pay	

		For State Registrar			n iviar	yland / L		irtment of H tificate of L			Reg. No	ZUL	) 4	04/25
Physicia /Medic		1. Decedent's Nam	e (First, Middle, La Y ELIZA		BEN	NETT	F	ISH		2. Date of De Month JANUA	RY Da	18 20	ear 204	3. Time of Death 6:30a <sup>M</sup>
Examin	er		If not institution, giv					4b. City, Town, or	Location of Dea	th		. County of I	Death	
			rtown Nu					Chester				ent		
Funeral Director		5. Social Security 1 159-34	-4574 <sup>1</sup>	6ex □ M 21X1F		'In yrs. last bin	Yrs.	If Under 1 Year Months Days	Hours Min		191		Count	ace (State or Foreign ry) Jersey
***		Usual Residence of 10a. State	10b. County		1	Oc. City, Town	n or Loc	cation					10	d. Inside City Limits
f sh	ğ	NJ	Glouce	ster		Westv	i 1 1	e						1∭∑Yes 2∐No
289	Director	10e. Street and Nu	mber					10f. Zip Code			10g. Cit	izen of Wha	t Count	ry?
23a o	a D	123 Av	on Ave.					08093	3		U.S	5.A.		
SE 9	Funeral	11. Marital Status		12. Was Dec Armed Fo	edent Ev	er in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No	)-	14. Race - A		
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Extendible 1 as building at once.	5	1 ☐ Never Man 3 🏿 Widowed	ried 2 Married 4 Divorced	1 ☐ Yes If Yes, Gi Year or □	2 🔀 No ve			☐ Yes 25€ No	Specify:	to Thous, Sto.,		Specify:		hite
netu	etec	(Spe	15. Decedent's Ed	ducation ade completed)		16a.	(Give I	ent's Usual Occupa	lurina most of wo	rkina	16b. K	ind of Busin	ess/Indu	ustry
. <b>Pa</b>	Completed	Elementary/Seco		College (	1-4or 5+)		life. C	OO NOT use retired)		,				
ther t		12 Father's Name	(First, Middle, Last)	1			НО	memaker	18 Mother's Na	me (First, Middle		wn He	ome	
ed of	Be		in Benne							oeth Jo		Sumame)		
mark matt	၉		ame/Relationship (			19b.	. Mailin	g Address (Street a				r Town. Sta	te. Zio (	<sup>Code)</sup> 21645
alth ar 27 is r freu		Dona1d			on)									
item othe		20a. Method of Dis	position	-		20b. Place of	Dispos	30 Ricks sition (Name of pattern or other place	DQUUL.	Date	20c. Lo	ocation - Cit	y or Tow	vn, State
nent c			☐ Cremation 3 ☐ 5 ☐ Other (Specify		State	Woodb	ury	Memori	a1 1/2	2/04	Woo	odbur	у,	NJ.
Departru Importe any inju		21. Signature of Fi	meral Service Lice	****		00510	Ga Ga	Name and Address 1ena Fu 8 West	s of Facility neral	Home of	E St	ephe	n L	Schaech
		23a. Part1. Enter	he disease, or com	plications that of	aused th		1					i, MD		1635 Approximate
hysisian		shock, or had Immediate Cause	hrt failure. List only (Final	one cause on a	each line.	/		_		. ,				Interval Between Onset and Death
hysician /Medical	Н	disease or condition resulting in death)	on	a. Due to	(or a a c	7/QM		5					_/	Typars
xaminer		Due to (or as a consequence of):  Sequentially list conditions,  b.												
=	ner	if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to	(or as a	consequence	of):							
and trans	Examiner	Cause (Disease or that initiated events resulting in death)	S	c	,					·-··				
ician				Due to	(or as a c	consequence	or):							
phys s the	ledicai		•	_ d										
within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delached for use as the burial-transit	cian/M	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2 9 Unknown	months?		oirth 2 ( nant at tin	pregnancy □ Fetal death ne of death		Ectopic pregnancy Other (specify)				23d. Date of Month		y Day Year
ed by	Physi		ficant conditions o	ontributina to d	eath but	not resulting in	the un	deriving cause give	n in Part I.	23e. Did t	obacco u	ise contribut	te to the	cause of death?
en signe	ted by		othproi	- /					,/	1 🗆 '				bly 4 □Unknown
e has be sge 2 sh	ompieted										osy irmed?	prior	to com	sy findings available pletion of cause of
tificat lor, pž	ပ္	25. Was case refer	rred to medical						26 Place of De	1 ☐ Yes ath (Check only o	2 No	10	Yes 2	!∐ No
is cer direct	0 8	examiner? 1 ☐ Yes 2	"No	Hospital: 1 🗆	Inpatient	2 🗆 ER/Out	tpatient	3□ DOA Othe	e .	lome 5 ☐ Resi		6 □Other (3	Specify)	17.0
th. After th funeral	tion; T	27. Manner of Deal 1. Natural 2 □ Accident	th 5 Pending investigation		of Injury th, Day Y	(ear) 28b. T	ime of njury	28c. Injury Work' M 1 □ Y	at	28d. Describe				
after dea Director d in by the	ertification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place	of Injury ing, etc. (	- At home, fai (Specify)	rm, stre	et, factory, office		28f. Location (S City or Tox			r Rural I	Route Number,
24 hours e Funere etely fille	edical C	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	niner: On the b	best of rasis of ex	camination and	, death d/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	and due to the arred at the time,	cause(s) date and	and manne I place, and	r as stat	ted. he cause(s)
rethin compl	Me	29b. Signature and	I title of certifier					29c. License	number		29d. Dat	e signed (M	onth, Da	ay, Year)
21.0		100	Ded	X1) 10	20			D 3	5099	6	1/1	19/20	004	
	-	30. Name and add	ress of person who	completed caus	se of dear	th (Item 23a) (	Type, F	Print) C Y	petpr	tono	MT	2110	20	
Sta	e	31. Date filed (Mor	oth, Day, Year)	200432. 8	legi dar's	Signature	k .	South a		100011	1.19	1 2-1 W		
Registra	ar		JAN & A	LOUT	1	A CENT	-	STATE OF THE PARTY						

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

AMEND#8 1/28/04 ANNE ARUNDEL CO. HEALTH ON PROPERTY OF THE ARUNDEL CO. HEALTH ON PROPERTY OF THE ARUNDEL CO. HEALTH ON PROPERTY OF THE ARUNDEL CO. 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Sallie R. Galloway January 2004 3:05 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 1920 Annapolis Nursing & Rehab. Anne Arundel 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1□M 2€ F 82 Yrs. Director 220-05-2944 March 5 - 10 S Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23e or 28e-1 ahow The Madical Examiner must be notified at t% Yes 2 □ No Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 Smithville Street 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2☐No Specify: Specify: Black δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Co. other then Elementary/Secondary (0-12) College (1-4or 5+) 12th0 Health Department Pages 1 and 2 should be filed v riment of Health and Mental Hygie rtant: If item 27 la marked other t niury or other treumatic event, III <u>Lab Technician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Powell Elizabeth Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 3 5 19a. Informant's Name/Relationship (Type, Print) Anna Galloway (Neice) 3111 Beards Point Rd. Davidsonville. Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Chews UM Church 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 1/29/04 Cowensville, Ma 22. Name and Address of Facility
Wm. Reese & Sons Mortuary 21. Signature of Funeral Service Licenses Lavy West St. Annapolis, 821 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anula Physician /Medical Due d (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be Completed by 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 2 No 2 ☑ No 1 Yes 1 Yes of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this nours after death. neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 | Homicide ō Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier > Work RADIO PARK 1220 A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 230 TOWSON 31. Date filed (Month Day, Year) AN 2 8 2004 istrar's Signature State Registrar

			WICHD, dq	State of Maryland / Dep		Mental Hygi	ene no	01.120
			1 - State Registrar Amend#18b, 0	01-22-04, PerFH Co	ertificate of Death	2. Date of Death	g. No.	04120
н	Physici	an	Decedent's Name (First, Middle, Las			Month	Day Yeer	3. Time of Death 22:53 M
	/Medic		JOHN W 4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat		9 2004 4c. County of Death	
	Examin	er		TEXAS ROAD	BIVALVE		WICOMIC	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) 9. Birth	place (State or Foreign
н	Director		212-28-8424	<sup>2 M 2 □ F</sup> 75 Yrs.	Mortal Days	4/10/28	8 Mar	y1and
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mary -1 sho	to	MD WICOMI	CO BIVAL	V F.			1 ☐ Yes 2 ☐ No
	r 28a	Irec	10e. Street and Number	00 , 51,112	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	th wit	al D	3841 TEXAS RO	AD	21814		U.S.A.	
	tems tems	uner	11. Marital Status	Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
36	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f show is Medical Enarther must be notified at	by Funeral Director	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>7</b> No If Yes, Give Year or Dates:	1 ☐ Yes 🌠 No Specify:		SpecifyWh it	ce ·
215-0036	2 hours	ted t	15. Decedent's Ed	ucation 16a. Dec	edent's Usual Occupation	1	6b. Kind of Business/In	ndustry
215	hin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) (Giv   College (1-4or 5+)	re kind of work done during most of wo DO NOT use retired)	rking	Home Impro	
21	filed with Hygiene. other than	Completed	11	- 1	inter	F	o <del>me Inpri</del>	vemt
<u>n</u>	d offi	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, M		
Z	d Men narke	ဥ	Werner Gruber  19a. Informant's Name/Relationship (7)	ivno Brint) 10h Ma	ling Address (Street and Number or Ri	Insley		- Code
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene the Health and Mental Hygiene them 23s or 28s-1 show item 27 is marked other then "natural", or items 23s or 28s-1 show other treumatic event. I've Medical Exertifier must be notified at		, , ,		o ser ser er		cesses where i	
	Heal Heal tem 2		Werner Gruber, 20a. Method of Disposition		Texas Road, E	Data	0 - 1 T	
ē	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 3 ☐: 14 ☐ Donation 5 ☐ Other (Specify	Removal from State Spring	ematory or other place) Gardens 1 Hill Memory	/19/04	Hebron, M	ſd.
Baltimore,	permit. Pages 1 and 2 shou Department of Health and IN Importent: If item 27 is man any injury or other treumat		21. Sign turn of Funeral Service Licens	) [ =9	22. Name and Address of Facility Messick Funera:			
0	20 = 3		Cornelius D.	Messes	BIVALVE, MARYL	AND 2181	.4	
Ш			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	cations that caused the death. Do not e	nter the mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a	EVD .			Onset and Death
	/Medical Examiner		resulting in dealiny	Due to (or as a consequence of):				
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):				
	d ansit	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events	•				
oʻ	e exectian an urial-tr	Exa	resulting in death) Last	Due to (or as a consequence of):				
68760,	icate be executed physician and s the burial-transit	dlcal		d				
_			IF FEMALE:	23c. If yes, outcome of pregnancy				
Вох	eath certifi attending I I for use as	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ery Day Year
P.O.	the d by the ached	ysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown				
	law requires that the death certif as been signed by the attending 2 should be detached for use a:	by Physiclan/M	Part II. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
Records,	w require been sig should b	edt				1 □ Yes	2 ☐ 1√0 3 ☐ Prob	oabły 4 ∏Unknown
ဝ၁	has be	plet				24a. Was an autopsy	24b. Were auto	opsy findings available
Ä	The ate h page	Completed				perform	ed? death? □\No 1 ☐ Yes	mpletion of cause of 2 No
Vital	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one	)	
of	Physi this c al dire	7	1 ☐¥es 2 ☐ No ☐ ☐ 27. Manner of Death	1 Impatient 2 ENOutpati		lome 5 Resider 28d. Describe how	nce 6 Other (Specif	(y)
O	ding After fune	tlon	1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. Describe nov	winjury occurred	
Division	Attending or death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury - At nome, farm, s	street, factory, office	28f. Location (Stre	et and Number or Rura	al Route Number,
Ö	s after	Certification;	4 ☐ Homicide determined	building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral			rsician: To the best of my knowledge, deainer: On the basis of examination and/or				
	To the H within 24 To the F complete	Medical	one)	and manner stated.				
	To To	<	29b. Signature and title of continer		29c. License number	29	d. Date signed (Month,	uay, rear)
				Ordered source of death // co-\ =	177047/		112909	
			30. Name and address of person who e	empleted cause of death (Item 23a) (Type	E Carrollst.	Salisby	MO 2180	4
	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar's Signature	E Carronst.			
	Registr	ar	IAN 2 2	2004 Serena A	J sporks			

			1- State of Maryland	Department of Health Certificate of Death		giene 200	14 04129
	Dhysisi	on	Decedent's Name (First, Middle, Last)		2. Date of De Month	ath	3. Time of Death
	Physici /Medi		LESTER P. GIVANS		Januar		
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		4c. County of 1	Death Dom/Co
			FENINGUIA KEGIONNI MEGICNI ( 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under	20,00		
100	Funeral Director		215-26-6138   ¹∑M 2□F   71	Yrs. Months Days Hours	7 24 Hzs. 8. Date of Bin Min. (Month, Da 02-16-		Birthplece (State or Foreign Country) ALISBURY, MD.
0	D		Usual Residence of Decedent		02-10-	1932 3	ALISDUKI,MD.
	arylar show	_	10a. State 10b. County 10c. City, T	own or Location			10d. Inside City Limits
	8a-1	Director		SBURY			1 XYes 2 No
	with th	Öğ	10e. Street and Number	10f. Zip Code		10g. Citizen of Wha	t Country?
	ss 23	erai	504 HAMMOND STREET  11. Marital Status  12. Was Decedent Ever in U.S.	21804		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show spirity or other traumatic event, Ite Medical Examinar must be notified at once.	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica		Black, V	American Indian, Vhite, etc. WHITE
Ö	72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation		16b. Kind of Busine	ess/Industry
2	ithin ne Ner	nple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	st or working		
	led w tygier her th		7	CARPENTRY		SELF EN	MPLOYED
and	I be fi	Be	AVERY W. GIVANS		er's Name (First, Middle,	Maiden Sumame)	
Maryland	hould d Me mark matic	ပ္		9b. Mailing Address (Street and Numb	IAN PAYNE	- Otto - T	7.0.1
Z Z	nd 2 s lth an 27 io			04 HAMMOND STREET			
ē,	s 1 ar f Hea item other	1	20a. Method of Disposition 20b. Place	of Disposition (Name of	Date	20c. Location - City	
Ë	Page nent o nt: If ry or		T Durial 2/10/11/2011 3 THOMOST HOM State	tery, crematory or other place) TORY OF DELMARVA	01_20_200/c T	DELMAD DE	ET ALIADE
Baltimore,	rmit. partit porta y inju	1	21. Algnature of Pineral Service Licensee	22. Name and Address of Facili	ity BOUNDS FUN	JERAL HOME	LAWARE L. INC.
<u> </u>	89 = 8		Jenor & Keller	705 EAST MAIN	STREET, SAL	ISBURY, MA	ARYLAND 21804
R			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as	cardiac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	G hollahis			Onset and Death
	/Medical Examiner		Due to (or as a consequence	e of):			
		ā	fi any, leading to immediate  Due to (or as a consequence	and are han			MINHS
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	o s.,.			
a,	exection and ital-tra	Exa	that initiated events c. Pue to (or as a consequence of the consequenc	e of):			
8760,	cate be executed physician and the burial-transit	dical	d				
9	ng ph as th	Med	IF FEMALE:				
Вох	that the death certifi ed by the attending t detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	th 3 □Ectopic pregnancy		23d. Date of	*
	the all	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)		Month	Day Year
0.	hat the	Ph)	Part II. Other significant conditions contributing to death but not resulting	Lin the underlying source succe in Cost I	220 Bid to	<b>.</b>	to the course of device
Records,	The law requires that the death certifi te has been signed by the attending i age 2 should be detached for use as	ted by	Marbil Chesty	THE WILL SHAPE CAUSE GIVEN IT PART			e to the cause of death?  Probably 4 □Unknown
ec	e law has b	Completed	Arrid Mulleton		24a. Was a	sv prior	autopsy findings available to completion of cause of
					perfor	med? death 2√2 No 1 ☐ Y	? 'es 2□ No
Vital		o Be	25. Was case referred to medical examiner?  Hospital: Hospital:	04	of Death (Check only or		
ō	Phys	$\vdash$	27. Manner of Death 28a. Date of Injury 28b	otpatient 30 box 40 Nu	rsing Home 5 Resid	ence 6 Other (S	pecify)
o	Attending I ir death. ector: After by the funer	tio	1 Avatural 5 Pending (Month, Day Year) 2 Accident investigation	. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐		on injury securiou	
Division of	l or Attending Phater death. Director: After the in by the funeral	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home.	farm, street, factory, office	28f. Location (S	treet and Number or	Rural Route Number,
<u> </u>	2 th 2 th 2	Certification:	4   Homicide Setember   building, etc. (Specify)		City or Town	n, State)	
	1 4 4 5 5 E	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date an and/or investigation, in my opinion, dea	d place, and due to the c th occurred at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
	To the within 2 To the complet		29b. Signature and Mile of pertifier	29c. License number		9d. Date signed (Mo	•
			I frammer has	JOHPR	. 9	1.25.	40
Q			30. Name and address Herson who completed cause of death (Item 23a		CA.	· Puly V	0 21822
X	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 /	SAC	ין יידיענו.	LIULL
10	Registra		JAN 2 7 2004 Beneva	& sparks			

			1- For State of Maryland / Department of Health and Maryland / Certificate of Death	Mental Hygier		04/30
	Physici		1. Decedent's Name (First, Middle, Last) Grea Gittings	2. Date of Death	ay Year	3. Time of Death
	/Medio Examin		4a. Facility Hame (If not institution, give streetand number)  4b. City, Town, or Location of Death Harford Memorial Hospital  Havre de Grace	7	to. County of Dear	
	Funeral Director		5. Social Security Number  3 14 - 14 - 0 145  1 M 2 F  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usuel Residence of Decedent	8. Date of Birth (Month, Day, Yee Pugust 23,	1945 Bal	thplace (State or Foreign buntry) Himore, MD
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location  MD Harford Hayre de Grace			10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 3a or 28e st be noti	Funeral Director	10e. Street and Number  10f. Zip Code  140 Bay Blvd.  21078	10g. (	Citizen of What Co	ountry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or items 23a or 28e-f show of other than "natural" or items 23a or 28e-f show event, I'm Medical Exacting resalte notified at	by Funer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Year or Dates: 175	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Ame Black, White Specify:	
21215-0036	within 72 hou ene. then "natura te Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	king 16b.	Kind of Business/	Industry
	ould be filed wi Mental Hygien ærkad othar th letic evant, Ita	Be	1	ne (First, Middle, Maid	ending en Sumame)	
Maryland	and and is m	ူ -	19a. Informant's Name/Relationship (Type, nt) (wile)  19b. Mailing Address (Street and Number or Rul  Shirky McNulty-Gittings  140 Bay Blvd Hay	Johnsor ral Route Number, City Ire de Gr		
altimore,	00			Date 20c.	Location - City or	Town, State
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	uneral Hi set, Aberd	ome, t.p	١.
	Physician		3a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	or respiratory arrest,		Approximate Interval Between Opset and Death Five days
	/Medical Examiner	16	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clease or wary that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
Box 687	eath certificate attending phys for use as the	n/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of deli	ivery
Ò.	that the death led by the atte detached for	Physician/M	1		Month	Day Year
ords, P.	w requires that been signed should be dei	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Colon Cancez	23e. Did tobacco		the cause of death?  obably 4
of Vital Records,		Completed	Anemia Ch-Renal Facture	24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
Vita	Physician: Th rthis certificate ral director, pag	o Be	examiner? Hospital: Other	th (Check only one)		
		<b>-</b>	1 Yes 2 No Tospital 1 Inpatient 2 ER/Outpatient 3 DOA 3 DOA 2 Nursing Hole 2. Manner of Death 1 Nursing Hole 2 Death 2 Sac Date of Injury (Month, Day Year) 2 Sb. Time of Injury Work? 2 Accident investigation 2 Accident Nursing Hole 2 Death 1 Yes 2 No	ome 5 Residence 28d. Describe how in		city)
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: Altei completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Ru ite)	iral Route Number,
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier	and due to the cause red at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	2 ₹ 2 8 1 ~ 1		Beeg MIRZA A-BAIG D4315-	230. 5	1-22	-04
	3 1		29b. Signature and title of certifier  29b. Signature and didle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Page trar's Signature  34. A page trar's Signature  34. A page trar's Signature  35. A page trar's Signature  36. Registrar's Signature  37. A page trar's Signature  38. Registrar's Signature	nace, N	1D 2	1078
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 3 2004  Separation of Signature			

Amend Item #3&22 State of Maryland / Department of Health and Mental Hygiene 2 Celtificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3:155 and **Physician** JANUARY 26 2004 GOLDBERG IDA /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner MONTGOMERY CARRIAGE HILL BETHESDA BETHESDA Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗓 F Yrs. Director 07/26/1908 MARYLAND 18-05-2235 Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MARYLAND MONTGOMERY CHEVY CHASE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filled within 72 hours efter death v Depertment of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural any injury or other traumatic event." #905 20815 U.S.A. Funeral 4701 WILLARD AVE. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☑ Widowed 4 Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) GOTTHELF MARY GOODMAN REUBEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6446 EDSALL ROAD, ALEXANDRIA, VIRGINIA 22312 LESLIE GOLDBERG/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEM. GDNS. 1/29/04 FALLS CHURCH, VIRGINIA 22 Name and Address of Eacilly EDWAROCR TITE UNERAL DIRECTION, INC. 21. Signature of Funeral Service Licenses udell 1091 ROCKVILL PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Examiner Due to (or es a consequence of) Physician/Medical Examine DYSPHAGIA I or Attanding Physician: The law requires thet the death certificate be executed effect death.

Director: After this certificate has been signed by the ettending physician end in by the invest director, page 2 should be deteched for use as the bune-trensit din by the invest director, page 2 should be deteched for use as the bune-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of). SEVERE VASCULAR DEMENTIA Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last HYPERTENSION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Ves 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔯 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide within 24 hours efter de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es steted.
2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 27, 2004 D35579 30 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 6844 TULPI HILL TERRACE, BETHESDA, MARYLAND 20816 SUSAN J. MILLER, M.D., 31. Date filed (Month, Day, Year) 32. Registrer's Signature State sacks JAN 3 0 2004 Registrar

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate o			iene 200!	04132
			Decedent's Name (First, Middle, La	st)				2. Date of Deal		3. Time of Death
	Physici /Medic		Lillian Gaul	t				Januar		
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town	, or Location of De	ath	4c. County of De	ath
			Manor Care Nurs			Silver If Under 1 Yes	Spring	50 0 0	Montgome	
	Funeral Director		579-16-9709	ex 7. Age □M 2⊠F	(In yrs. last birthday) 83 Yrs.	Months Day			Year) 9. B	rthplace (State or Foreign country) MD
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl	ţ	MD Prince G	eorge's	Adelphi					1K∑Yes 2 ☐ No
	with the	I Director	10e. Street and Number 8005 Riggs Rd.			10f. Zip Code	20783	1	Og. Citizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itame 23e or 28e-f show many injury or other traumatic event, the Hydical Eval in an inneal be inclified at ODGS.	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a, Dece	dent's Usual Occ	cupation	dviaa	16b. Kind of Busines	s/industry
215	hin 7.	pie	(Specify only highest gri	de completed)  College (1-4or 5+	life.	DO NOT use ret		rorking		
21	ed wit	Com	11		Cross	sing Gua	1		P. G.Coun	ty
ıland	uld be fill Mental Hy rked oth	To Be	Joseph A. Phelps					ame (First, Middle, I		
Baltimore, Maryland	nd 2 sho alth and I 27 is me		19a. Informant's Name/Relationship ( Iona Flynn - Sist						ng, MD 209	
ore,	of Head		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other p	olace)	Date	20c. Location - City o	r Town, State
Ĕ	Pag ment ent: p		* 4 □ Donation 5 □ Other (Special	y)	Geo. Was				Adelphi, M	D
3alt	Depart Depart Import any inj		21. Signature of Funeral Service Lice	1.14.11		2. Name and Add			aldi F. H.	30001
	40 E # 0		23a. Part 1. Enter the disease, or com	nlications wat raused t						ng, MD 20904 Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	1e/anov		,			Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or se s	consequence of):					
8760,	icate be executed physician and s the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
.O. Box 68	ne death certif the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other <i>(specify)</i>			23d. Date of do	blivery Day Year
٥.	uires that the signed by d be detact	þ	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause	given in Part I.	23e. Did tot		to the cause of death?
ecords,	w requir been si should	eted								and the same of th
$\propto$		Completed						24a. Was a autops perform	prior to ped? death?	utopsy findings available completion of cause of s
Vital	Physicien: Th r this certificate ral director, pay	Be (	25. Was case referred to medical examiner?	Manitali			_	eath (Check only on	99)	
<b>d</b>	Phys this al di	၉	1 Yes 2 No	Hospital: 1 Inpatien		II 3 DOA			ence 6 Other (Sp ow injury occurred	ecify)
ion	ding h. Afte fune	ation;	27. Manner of Death  Natural 5 Pending  Accident investigation		Year) 285. Time o	V	vork? □ Yes 2 □ No	280. Describe no	ow injury occurred	
Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, st (Specify)	reet, factory, offic	C8	28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or within 24 hours after to the Funerel Dir completely filled in	edical		nysician: To the best of miner: On the basis of e and manner state	examination and/or in					
	To the within 2 to the complet	Me	29b. Signature and title of certifier	1. M. T.			ense number		9d. Date signed (Mor	
)	b(i)		Jenn	14 May to	~	D	43260	41:	January	28, 200 4
	7		30. Name and address of person who				urol MD	20707		
			Jenny Y. Moy, M.	D. 13952 E		Ave. La	urel, MD	20/0/		
	Sta Registi		JAN 29 20	04 Sper	Signature &	Spark	21			

			For	St			d / Depa	artmen	t of H	ealth a		ental Hy	giene	2001	. 04	133
			State Registrar				Cei	rtificat	e of L	Jeatn		2. Date of De	Reg. No.		3. Time o	Dogth
	Physicia	an	Decedent's Name (First, Mide	lle, Last)								Month	Day	Yeer		a M
	/Medic		Lydia	E		Gat	es		+	1	4 D = + h	Januar	_	, 2004 County of Dear	1:30	a
	Examin	er	4a. Fecility Name (If not instituti							Location o	Death					
			Montgomery Ho 5. Social Security Number	spice-		ey Hous '. Age (In yrs.			1 Year	/111e	24 Hrs.	8. Date of Birt (Month, Da		ontgome 9. Bir	thplace (State ountry)	or Foreign
	Funeral Director		579-07-8715	1 M		92	Yrs.	Months	Days	Hours	Min.	(Month, Da April 8	y, Year) 191	1 Mic	chigan	
			Usual Residence of Decedent									mpr 11 0				
	how how		10a. State 10b. Count	у		10c. Cit	y, Town or Lo	ocation							10d. Inside C	ity Limits 2.⊠No
	a-f s	cto	Maryland Mon	tgomer	у			Bethe	sda							2 23 140
	death with the Maryland ms 23e or 28e-f show r must be notified at	Directo	10e. Street and Number					10f. Zip					10g. Citiz	en of What Co	ountry?	
	ath w 23a	ral	5803 Aniston						2081		1.0/0	7 1 1		USA 4. Race - Ame	riana Indian	
	tams	Funeral	11. Marital Status	Α.	rmed Ford		.S. 13.	Was Deced	dent of Hi city Cuba	spanic Origin, Mexican	gin? (Spe 1, Puerto f	cify Yes or No Rican, etc.)	'	Black, Whit		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Ma 3 🖾 Widowed 4 ☐ Divorce	1	☐ Yes 2 Yes, Give Year or Da	)		1 🗆 Yes	2 🖾 No	Specify:				Specify: Wh:	ĺte	
Ş	filed within 72 hours after Hygiene. other than "natural", or Ita sht, the Medical Examina	edi	15. Decede	nt's Educatio	n		16a. Dece	dent's Usu	al Occupa	ation				d of Business		
215	7 nin 72	Completed	(Specify only high Elementary/Secondary (0-12)		n <i>pleted)</i> College (1-	4or 5+)	life.	DO NOT u	se retired	during most )	t of workir	ng	Nat	ional : of Hea	Institu	tes
21.	d witi	mo;	12				(	Clerk								
2	al Hygir d other vent, t	0	17. Father's Name (First, Middle							18. Mothe	er's Name	(First, Middle,	Maiden S	Sumame)		
yla	2 should be filed within 72 hours after death with the Marylan and Mental Hyghens is marked other than "natural", or Itams 23a or 28a-f show aumatic event, it a Medical Exacticar mast be notified at	은	Otto Se	idel			<del></del>				<u> </u>	Schwa1				
Maryland 21215-0036	2 sh and ls m		19a. Informant's Name/Relation					_				l Route Numbe				
	1 and 1ealth Im 27 ther to		William Lewis 20a. Method of Disposition	Gates	/ Sor		2600 Place of Dispo			k Str		Bethes		MD 208 ation - City or		
õ	Pages nent of thint: If Its iny or of		1 ☐ Burial 2 ☑ Cremation		wal from S	itate	semetery, cre	matory or o	other place			ry 23				
Baltimore,	rtmer rtant njury		*4 □Donation 5 □ Other  21. Signature of Fuperal Service			Met	ropol	2 Name at	nd Addres	s of Facilit	hv	004			a, Virg	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		To be t	57 6	Em	u	F	ranci	s J.	Coll	ins :	Funeral	Hom	e Inc.	ing, MD	20901
Y	\$		23a. Part1. Enter the disease,	or complication	ons that ca	used the deat								CI DPI.	Approxima Interval Be	te
	Physician		shock, or heart failure. Li Immediate Cause (Final	st only one ca		ition									Onset and	Death
	/Medical		disease or condition resulting in death)	a		or as a conseq	uence of):								1 yea	<u>r</u>
61	Examiner		O and anti-the link and distance	, h												
	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>)</b> "-	Due to (d	or as a conseq	uence of):									
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	D											
760,	ate be executed hysician and he burial-transit	E	resuming in death) cast		Due to (d	or as a conseq	uence or):									
	death certificate b attending physic	dlcai		d				-								
× 6	ding ding se as	Completed by Physician/Med	IF FEMALE:	23c. I	f yes, outo	ome of pregna	ancy						2	3d. Date of de	livery	
Box	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live bi	nth 2 ☐ Fete ant at time of d	ol death 3[	□Ectopic p □ Other (s						Month	Day	Year
0	that the de sed by the a detached t	hysi	9 Unknown		9 Unkno	wn										
ري ت	s that med be e det	y P	Part II. Other significant cond		-	ath but not res	ulting in the u	inderlying (	cause give	en in Part I.		23e. Did t	obacco us		o the cause of	
rd	w requires that been signed I should be det	ed t	Alzheimer's	Disea	se		-					10'	Yes 2	₹No 3□P	robebly 4 🗆	Unknown
000	ne law re has bea	plet										24a. Was	osv	24b. Were a	utopsy findings completion of	available cause of
m m	The ate he page	Com											rmed? 2 🔀 No	death? 1 ☐ Yes	2 □ No	
ita i	sian: artifica ictor,	Be (	25. Was case referred to medi examiner?						101		of Death	(Check only o	one)			
5	hysic this o	은	1 ☐ Yes 2 ☒ No	Hosp	1 📙 Ir	·	ER/Outpatie			4 (A) NU		ne 5 Resident			ecify)	
Division of Vital Records, P.	ling F	lon:	27. Manner of Death  1 ☒ Natural 5 ☐ Pen	ling	8a. Date o (Monti	h, Day Year)	28b. Time o Injury	м	28c. Injury Work 1 □ '	yat k? Yes 2. □		zad. Describe	now injury	occurred		
isi	death death stor: / the	icat	3 ☐ Suicide 6 ☐ Cou		8e. Place	of Injury - At h	ome, farm, st					28f. Location (	Street and	Number or R	ural Route Nur	nber,
<u>≤</u>	after Direction of the plane of	Certification:	4 Homicide	mined 2	buildin	ig, etc. (Specia	fy)		,,			City or To	wn, State)			
	spita hours neral y filled		29a. Certifier 1K Certif	ing Physicie	n: To the	best of my kno	owledge, deal	th occurred	at the tim	ne, date an	nd place, a	and due to the	cause(s)	and manner a	s stated.	- \
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medic	al Examiner:	and mann	er stated.	ation and/or in				in occurr	ed at the time,			e to the cause(	>)
	To I To I	Σ	29b. Signature and title of certi	ier	, )		00	)	c. License						th, Day, Year)	
	8		1 ) he	00/5	en	eda,	lud		D001	3187			Ja	nuary 2	23, 200	4
			30. Name and address of person			//					. 1	/.00 a		Oh e -	MD 000	ıE
	Sta	to.	J. Neill Kent 31. Date filed (Month, Day, Ye		32. Re	egistrar's Signa					re 1	400, Ch	evy_	onase,	MD 208	1.)
	Registi			6 2004		Bankersen	[3	S	ice de							
			UIII.													

			For State Registrar	State of Marylar		irtmen <i>tificate</i>			d Mei		giene Reg. No	-2111	4 04	131
	Physici	an	1. Decedent's Name (First, Middle, Last)							Date of De Month	Da	y Year	3. Time of	
	/Medi	cal	Anita Stev  4a. Facility Name (If not institution, give st		<b>a</b>	4b. City.	Town, or L	ocation of E		anuary		, 2004 County of De	10:52	- A M
	Examir	ner	Suburban Hospita				thes					Montg		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year	If Under 24	Hrs. 8.	Date of Bir (Month, Da	th v Year		rthplece (State o.	r Foreign
	Director		462-14-4726	M 25kF 84	Yrs.	MODITIS	Days	Hours		in. 9,		20 T	exas	
_	pur M		Usual Residence of Decedent  10a, State 10b, County	10c. Ci	ty, Town or Lo	cation							10d. Inside Cit	ty Limits
	Varyla 1 sho	ō	Maryland Montgomer		Bethese	4.							1 🗆 Yes	2 ₩ No
	the real	rec	Maryland   Montgomer  10e. Street and Number	- У	Detnes	10f. Zip	Code				10g. Ci	itizen of What C	Country?	
	death with the Maryland rms 23a or 28a-f show	aiD	8505 Woodhaven Blv	d.				20817			Un	ited St	ates	
		Funeral Director	11. Marital Status	<ol><li>Was Decedent Ever in L Armed Forces?</li></ol>	J.S. 13. V	Vas Deced f Yes, spec	dent of History Cuban,	panic Origin , Mexican, P	? (Specification )	y Yes or No an, etc.)	)-	14. Race - Am Black, Wh		
36	within 72 hours after ene. than "natural", or Ite he Moulcal Exterelline	by Fu	1 ☐ Never Married 2 ☒ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 [ <b>X</b> No If Yes, Give Year or Dates:	1	1 □ Yes :	2 <b>⊋</b> No	Specify:				Specify: W	hite	
Ö	72 hours natural', alcal Ex	ed b	15. Decedent's Educ		16a. Deced	ient's Usua	al Occupati	ion			16b. F	Cind of Busines		
15	n "natu	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of woi DO NOT us	rk done du	ring most of	working					
212	d with giene ar tha	Completed	Elementary/Secondary (0-12)	5+	Tea	cher						Educat	ion	
P	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)				1	18. Mother's	Name (F	irst, Middle,	Maide	n Sumame)		
≥ s	should to	ို	Charles A. Stewar					Lola V						
S. Maryla	12 sh h and 7 is m rraum	1	19a. Informant's Name/Relationship (Typ			•	•					or Town, State,	, ,	
$/$ $\mathcal{OSL}$ $\mathcal{L}$ $\mathcal{M}$	s 1 and 2 should be filed within is 1 and 2 should be filed within and Mental Hygiene. If tem 27 is marked other than other traumatic event, Its M.		Moises Garcia/Hus	20b.	Place of Dispos	sition (Nan	ne of		Date			lary land Location - City o		
C C I	Ser in a ser		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		cemetery, cren Mont Cremato				anuar	1	eth	esda, M	faryland	
	permit. Pages 1 Department of I- Importent: If Ite any injury or ot	-	21. Signature of Funeral Service License		Cremato	rium. . Name an	d Address	of Facility I		114		-	uneral H onsin Av	
ä	permit. Depart Import any inj	1	1 ELY 1503	M01	356 Be	theso	la-Ch la. M	evy Cl arvla	nase, nd 20	.lnc 814-3	/5: 501	5/ Wīsc	onsin Av	<i>r</i> enue
	# . **		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the dea									Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	Respirator	y Failu	re							Onset and Day	
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							-		
5	*	_	Sequentially list conditions, b.	Stroke Ous to (or as a consu	quenca ::f):								6 Day	rs
70/5-	bed nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		900100019									
\ .	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):									
/ / 8760.	cate be physicia the bur	dical	d.											
9		Medi	IF FEMALE:											
Pox Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet	al death 3	Ectopic pr						23d. Date of de Month		rear
- o	t the dee by the al	/sici	1 Yes 2 XNo	4 Pregnant at time of 9 Unknown	death 5	Other (sp	ecify)							
	that the ed by detac	Ph	Part II. Other significent conditions conf	tributing to death but not re	sulting in the ur	nderlying c	ause given	n in Part I.		23a. Did t	obacco	use contribute	to the cause of d	eath?
ACC ام الط Vital Records.	uires tha									1 🗀 `	Yes 2	2 □ No 3 □ F	Probably 4 🙀	Inknown
_ 00	w require been si should l	Completed								24a. Was		24b. Were a	autopsy findings	available
C19	The lav	E G							_	autor perfo 1 ☐ Yes	psy ormed? 2⊠No	prior to death? o 1 □ Ye	autopsy findings a completion of ca s 2 No	ause of
Z E	ician: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of	Death (C			0 1016	3 2 140	
	nysici nis ce direc	To E	examiner? 1 Tyes 2 XNo	ospital: 1 🔀 npatient 2	ER/Outpatien	at 3□ DC	Other	4 🗌 Nursi	ng Home	5 🗌 Resi	dence	6 □Other (Sp	ecify)	
	ding Ph n. After th funeral		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury a Work?			I. Describe	how inju	ury occurred		
Division	Attending Physician: r death. sctor: After this certifica	ertification:	2 Accident investigation 3 Suicide 6 Could not be	Office of Injury At h		M		es 2 □ No		Location (	Stroot	and Number or I	Rural Route Num	bor
į×į	in Site	ertifi	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	eet, ractory	/, oπice		201	City or To	wn, Stat	(e)	nurai moute ivum	Der,
_	pita ours erei	O		ician: To the best of my kn										
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medice! Examin one)	er: On the basis of examinand manner stated.	ation and/or inv	vestigation	, in my opii	nion, death	occurred					) 
	To the To the comp	Σ	29b. Signature and title of certifier	~-1		290	License	number	1		29d. Da	ate signed (Mor	nth, Day, Year)	
	1		11.1-100	~ ~		1	141	5+	0		1	125/0	1	
			30. Name and address of person who cou	mpleted cause of death (Ite	m 23a) (Type, 1000/M	Print)	A1.	6#	812	At	TH.	6509	MO DA	18711
	C+	oto	31. Date filed (Month, Day, Year)	32. Reģistrar's Sigr		1	11-	VTI	017	70	<i>,((</i> !	FIRE	1 1/2 ~	017
	51	ate	31. Date filed (Month Day, Year)	14 Degreens	1	10	no Ko	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** GONCE LENA DOROTHY IAN 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFOND If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 92ACE MEMORIAL HOSPITAL HARFOLD Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2XX 1931 Maryland December 17, Director 212-30-5759 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Expiriting Instituted at ADE. 1XXYes 2 □ No Director Perryville Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 542 Aiken Avenue 21903 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Stewart Walter Simpers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 74, Perryville, Maryland 21903 Jeffrey A. Gonce/Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
orth East Methodist 1 △Burial 2 □ Cremation 3 □ Removal from State January 30, North Ea Cemetery `4 ☐ Donation 5 ☐ Other (Specify) North East, Maryland 2004 21. Signature Fore Service Lies ee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physician and use as the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown MELLITUS 1 ☐ Yes 2 ☐ No IABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe deatn? 1 ☐ Yes 2 ☑ No After this certificate 2. No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification; To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel of within 24 hours af To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1 AN 25, 2004 D21800 James 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1140 VIUM MD 21093 PAASHO RK no 2336 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2004 Registrar

DHMH 17 Rev 1/2001

ime of Dadh-10:15

sonce, Dorothy

		1 - For State Registrar	State of Maryla	•	artment of rtificate o			giene Reg. No. 200	4 04 136	
Physic	cian	1. Decedent's Name (First, Middle, Last)			-		2. Date of De Month	eath Day Yea		
/Med Exam		Willie Mae Ha			4b. City, Town	n, or Location of I	Januar Death	y 21 2004 4c. County of De		
		HCR/Manor Care				Largo			e George's	
Funera Directo		5. Social Security Number 6. Sex 1 1	M 2 X F 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Ye Months Day		Min. (Month, Da	ay, rear)	irthplace (State or Foreign Country) uth Carolina	
		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits	
Maryla -1 sho	tor	Maryland Prince		1	Clin	ton			1X Yes 2 □ No	
ith the or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?	
eath w ns 23a must I	Funerai	5411 San Juan Dr	rive 2. Was Decedent Ever in	U.S. 13.	Was Decedent of	2073 of Hispanic Origin			d States	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other then "naturel, or Items 23a or 28a-f show any injury or other treumatic event, Ite Mudical Ever injury or other treumatic event, Ite Mudical Ever injury and other treumatic event.	P S	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify C 1 ☐ Yes 21 N		n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. African Specify: American		
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occ	ne durina most o	f working	16b. Kind of Busines		
within lene. then	ompi	Elementary/Secondary (0-12) 4th	College (1-4or 5+)	life.	DO NOT use ref	<sub>ired)</sub> ekeeper		Priv	ata	
al Hyg	BeC	17. Father's Name (First, Middle, Last)			1.045		s Name (First, Middle,			
hould to Ment marked	70	John Owens  19a. Informant's Name/Relationship (Typ		10h Mailir	na Address (Stra	not and Number		nie Owens er, City or Town, State	Zin Code)	
nd 2 sl alth an 27 is i		Lorraine Horton			•		r., Clinto			
ges 1 a t of He if Item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	sition (Name of natory or other p		Date	20c. Location - City of		
nit. Pa artmen ortent: injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service LiCense			Memoria.		1/31/2004   Stewart	Landove Funeral He	•	
Departing any irreport	N N	John T. Ster	IT trou				Rd., N.E. V		20019	
		23a. Parti. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final	ations that caused the dea cause on each line.	ath. Do not ent	er the mode of d	lying, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
Physiciar /Medica	ı	disease or condition resulting in death)	Congest:  Due to (or as a conse	<u>ive Hea</u> quence of):	rt Fail	ıre				
Examine		Sequentially list conditions, b.	Coronary  Due to (or as a conse		y Diseas	se				
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conse	quence on.						
icate be executed physician and sthe burial-transit	i Exa	resulting in death) Last	Due to (or as a conse	equence of):			·			
ficate the property of the control o	edicai	d.		· · · · · · · · · · · · · · · · · · ·						
w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnar	ncy		23d. Date of d	elivery Day Year	
the dea y the all	iysici	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5	Other (specify)			World	Day 16a	
s that i	by Ph	Part II. Other significant conditions cont		sulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?	
require	eted	Cancer of Br							Probably 4 DUnknown	
sician: The law scertificate has b	ompieted	Chronic Obst	ructive Pulm	nonary .	Disease			osy prior to ormed? death?		
ian: T itificat ctor, pa	Be Co	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes f Death (Check only o	21	s 2 No	
Physic this ce al dire	은	1 ☐ Yes 2 XNo		ER/Outpatier	I SO DON			dence 6 Other (Sp	ecify)	
*Attending Physician: The ler death. rector: After this certificate his by the funeral director, page	ation	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	vork? □Yes 2□No		how injury occurred		
el or Atters after dez	27. Manner of Death 1 Mantural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred							Rural Route Number,		
To the Hospitel or Attending Physician: The law requires that the death certific Within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending promptle in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier 1 A Certifying Physic (Check only one) 2 Medical Exemin	cian: To the best of my kr er: On the basis of examir and manner stated.	nowledge, deatl	n occurred at the vestigation, in m	time, date and p y opinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)	
To the Comp	ž	29b. Signature and title of certifier	1.10		29c. Lice	51520		29d. Date signed (Mor	nth, Day, Year) 22, 2004	
(3)		30. Name and address of person who con	npleted cause of death (Its	m 23a) (Tune	Print)	J1J20		Januar y	22, 2004	
Je		Dahram Pishd				, Clint	on, MD 20	)735		
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature						

ELYSSIA GREEN

the Maryland

with (

death

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#1 State of Maryland / Department of Health a 1- State Unpend Item#23a, PartII, 27, Per ME, Case Microsoft Death State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Elyssia D. Greene Hicks Elyssia D'Oma Hicks 27, 2004 JAN. 11:12 A<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL GENERAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. Year Septy 21 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 □ M 2 🕅 F 9 Maryland 214-43-1834 1994 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits itema 23a or 28a-f show the Medical Examiner must be notified at 1. Yes 2 □ No Director Anne Arundel Maryland Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4675 Sands Road 20776 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. of fled within 72 hours after all Hygiene.

Other than "netural", or fte Never Married 2☐ Married Specify: Black 1 ☐ Yes 2 🖺 No Specify: 9 3 Widowed 4 Divorced "netural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 4th College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other tt
any injury or other traumatic event. IIIs
ODG. Student Lothian Elementary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gregory A. Hicks Tamasha Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamasha Greene (Mother) 4675 Sands Rd. Lothian, Md. 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Moses Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2/2/04 Drury, Maryland 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A.
821 West St. Annapolis, Md. 21401 21. Signature of Funeral Service Licensee January & Reese Moo 883 | Wm. Reese & Sons Mortua: 821 West St. Annapolis, 23a. Part1. Enter the Assass, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis Complicating Sickle Cell Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Reactive Airway Disease Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and resulting in death) Last Due to (or as a consequence of) attending physicien Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 1 Yes 2 No 3 Probably 4 Xunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Was an has certificate 1 Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 X Yes 2 ☐ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1▼ Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. Physician: ef or Attending P s after death. I Director: After t d in by the funera filled in by

within 24 hours a To the Funeral C

State Registrar

Medical

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID LING. LI

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Dey, Year)

JAN.

28, 2004

29c. License number

O.C.M.E

31. Date filed (Month, Day, Year)

h

FEB 0 3 2004

32. Registar's Signature

			1 - For State Registrar	State of M	laryland		artment rtificate			and M		giene Reg. No	2110	T. P.	04138
	Physici		Decedent's Name (First, Middle, Las     Gordon Wayne Hai	•							2. Date of Dea Month	De		r	Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give		)		4b. City,	Town, or	Location o	f Death	January		2004 County of De		11:05 A
			111 Wardour Driv						Annap				nne Ar		
	Funeral Director		5. Social Security Number 6. Sec. 213–48–9349	X 7.A ZM 2□F	ge (In yrs. Ias 53	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	v, Year)			(State or Foreign
i e	122		Usuel Residence of Decedent								Aprii 2	oril 27, 1950 Maryland			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygene. Important: if Item 27 is marked other than "natural", or Itame 23e or 28e-f show spiritury or other traumatic event, the Madical Examiner must be notilized at ance.	ctor	Maryland Anne Art	undel	10c. City,	Town or Lo	cation	A	nnapo	olis					Inside City Limits
	with th	Director	10e. Street and Number				10f. Zip	Code	21.404			10 <b>g</b> . Cit	izen of What (		
	eath ve 23c	Funeral	111 Wardour Drive	12. Was Decedent	Ever in II S	13.1	Nas Deced	lent of Hi	21401		city Vee or No-		U.S		ndian
920	urs after d al', or Itan	þ	1 Never Married 25 Married 3 Widowed 4 Divorced	Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	'	f Yes, spec		Specify:	Puerto F	cify Yes or No- Rican, etc.)		Black, Wh		
Maryland 21215-0036	72 hor	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced	dent's Usua	l Occupa	ition	of workin	a	16b. Ki	ind of Busines	ss/Industr	ry
12	within ne. ihan "	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us								
0 0	Hygie Hygie other 1	o Co	17. Father's Name (First, Middle, Last)	5+		F'1	nanci	al C			(First, Middle,	Maiden	Final	nce	
an	ould be Mental arked o	To Be	Basil Gordon Hami	11							ppler		00		
ary	2 should and Men is marke		19a. Informant's Name/Relationship (T	•		19b. Mailin	g Address	(Street a	nd Number	r or Rural	Route Numbe	r, City o	r Town, State,	, Zip Cod	de)
	and and math		C. Taney Hamill/v	vife	loo. B		Wardo		rive		apolis,	_			
Baltimore,	Pages 1 nent of H int: If the		20a. Method of Disposition 1 Burial 2 Peremation 3 1	Removal from State	cen	ce of Dispo netery, cren	natory or ot	her place			/OOO		cation - City o		
	artmer artmer ortant injury		*4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Services Licens		Bal	timor					/2004 n M. Ta		timore,		
Ba	permit. Departn Importe eny injk		food	ミノ ス	ille						er St.				
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that cause ne cause on each I	d the death. ine.	1		of dying	g, such as o	770	respiratory arr			Inte	proximate erval Between set and Death
84.) (35)	Examiner			Due to (or as	a conseque	nce of):		- 177	100						
	nsit	Examiner	if any, leading to immediate cause (Disease or injury	b. Due to (or as	a conseque	nce of):									
8760,	cate be executed obly sician and the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):				<u>-</u>					
Ö	tificate ng phy as the	Medic	VE 5511115	0											
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal de	eath 3	Ectopic pre Other (spe					2	23d. Date of de Month	elivery Day	Year
۵.	res that the de igned by the a be detached f		Part II. Other significant conditions co	ntributing to death b	out not resulti	ng in the un	derlying ca	use give	n in Part I.		23e. Did tol	bacoo u	se contribute	to the ca	use of death?
Records,	w requires been sign should be	sted by									1 🗆 Y	es 2	3 No 3 □ F	robably	4 Unknown
Vital Rec		Completed										ped? 2 D No	24b. Were a prior to death?	complet	findings available tion of cause of No
	ysician: is certific director,	o Be	25. Was case referred to medical examiner?	fospital:	ent 2∏ER	VOutpatient	3□ DO4	Other	r	of Death	C eck on on		S □Other (Sp	acrár)	- W-1111
on of	ding Ph After th funeral	tlon: T	Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		8b. Time of Injury		c. Injury Work		28	3d. Describe ho			ocny)	
Division	I or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At home c. (Specify)	e, farm, stre			71.75		3f. Location (St City or Town	reet and n, State)	d Number or F	Rural Rou	ute Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best ner: On the basis o and manner st	f examination	edge, death n and/or inv	occurred a estigation, i	t the time	e, date and inion, death	place, ar	nd due to the ca	ause(s) ate and	and manner a place, and du	is stated.	cause(s)
	To th within To th compl	Me	29b. Signature and little of certifier	10	//.		29c.	Licerse	number 2	(ب	2	9d. Date	signed (Mon	oth, Dey,	Year)
			30. Name and address of pers   who co	empleted cause of	ath Hem 2	3a) (Type, F	Print)		, / )	5/		193	nuay	1 -	12004
(2)			Russell Q Del	32. Fagistr	ar's Signatur	105	Juli	027	VC)	6	en O	ميل	se Me	1.2	1041
F	Sta Registr	6.00	JAN 2 8 20	104		× A	me le						)		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Sherwood Divan Holland, Sr. January 26, 2004 7:07 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 □ F Director 12, 1962 220-84-6130 Maryland Nov. Usual Residence of Decedent e filed within 72 hours after death with the Marylend at Hygiene. other than "naturel", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 263 Whitaker Road 21122 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√TNo 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Yeer or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professional Driver Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fii f Haaith and Mantal H Item 27 Is marked ott Be Wayne Elroy Holland Gladys Pack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Haaith a Important: if Item 27 Is eny injury or other tra-Pasadena, Maryland Mildred Louise Holland (Wife) 263 Whitaker Road 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Jan.30, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Town Neck Meth. Cemetery Asburý 4 ☐ Donation 5 ☐ Other (Specify) 2004 Severna Park, MD. Church 22. Name and Address of Facility Adams Funeral & Memorial Care 21. Signature of Furieral Service Licensee M00982 814 Bestgate Rd. Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ٥ After this certificate has been signed funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Tes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fo investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) of de (th (Item 23a) (Type, Print)

State Registrar Edward

wort 31. Date filed (Month, Day, Year) JAN 2 9 2004

30. Name and address of person who completed cause



Greens

and Sherwas

			1 - For State Registrar		partment of Health and ertificate of Death	Mental Hygie	
	Physici		1. Decedent's Name (First, Middle, Last)  Thomas R. Hicks			2. Date of Death Month January	Day Year 27 2004 2215 M
	/Medic Examir		4a. Facility Name (If not institution, give street and Anne Arundel Medica		4b. City, Town, or Location of De	ath	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 12-52-4053 15 M 20F	7. Age (In vrs. last birthday	^	rs. 8. Date of Birth	
packac	2	5	Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits 1 Yes 2 □ No
With the M	t or 28e-f	Directo	Maryland Anne Arun	del  Glen B	10f. Zip Code	10g.	Citizen of What Country?
1215-0036	or items 23s	by Funeral Director	1 Never Married 2 Married 1 Yes.	s 2 ∰No Give	21061  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pus 1 □ Yes 2 □ No Specify:	(Specify Yes or No- arto Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black.
21215-0036	nen 'neturej' nan 'neturej' n Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) (Giv ife.	edent's Usual Occupation e kind of work done during most of w DO NOT use retired)	orking A	n. Kind of Business/Industry  nne Arundel Co.
Maryland 21	should be fried wand Mental Hygier the marked other the tumatic event, Ital	To Be Cor	11th  17. Father's Name (First, Middle, Last)  Edward C. Hicks	0 Tri		Pej ame <i>(Firs</i> t, <i>Middl</i> e, <i>Maid</i> rlotte Gra	
re, Mary	perinit. Tages i rainz should be filed writin 72 flouts after beaut with the warytal perinit. Tages i rainz should be filed the filed flower the filed flower than "neturel", or items 23a or 28e-1 show any injury or other treumatic event. If the Michigal Examinat i list by nufficial and once.	-	19a. Informant's Name/Relationship (Type, Print)  Cynthia Hicks (Wife 20a. Method of Disposition	) 14 I 20b. Place of Disp	ling Address (Street and Number or Alicks Ave. Anna position (Name of	apolis, Mo	
Baltimore,	Department of Importent: If i any injury or once.		1  Burial 2  Cremation 3  Removal fro 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee	Park	aneton Memoria al 2/2  22. Name and Address of Facility  VM. Reese & Sons Mori	0.0	nnapolis, Md. 2140
E	/Medical /wasician and // // // // // // // // // // // // //	cal Examiner	Sequentially list conditions, if any leading to amount a cause. Enter Underlying Cause (Disease or injury that initiated events c.	at caused the deeth. Do not en each line.  It (or as a consequence of):  It (or as a consequence of):  It (or as a consequence of):	nter the mode of dying, such as cardi	ac <sup>l</sup> or respiratory arrest,	Approximate Interval Between Onset and Death
Box 6	ed by the attending phy detached for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Un		23d. Date of delivery Month Day Year		
rds, P.O.	s been signed by should be detac	by	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
al Reco	is certificate has beedirector, page 2 sho	Completed				24a. Was an autopsy performed	
Division of Vital Records,	r death. ector: After th by the funeral	Certification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	Anpatient 2 ER/Outpatie te of Injury onth, Day Year)  28b. Time Injury Injury At home, farm, s	ont 3 DOA Other: 4 Nursing of 28c, Injury at Work? M 1 Yes 2 No	eath Check onl one Home 5 Residence 28d. Describe how in	ijury occurred  and Number or Rural Route Number,
UI To the Hospital or	hours afte nerel Dir filled in	edical Cert	29a. Certifier 1 Pertifying Physician: To (Check only 2 Medical Examiner: On the	basis of examination and/or i	th occurred at the time, date and plac ovestigation, in my opinion, death occ	city or Town, St. e, and due to the cause curred at the time, date a	o(s) and manner as stated
Tothe	within 24   To the Fu	Med	29b. Signature and title of certifier  30. Name and address of person who completed ca	anner stated.	29c. License number D \$\infty 5  \text{8Z97}		Date signed (Month, Day, Year)
	- 01		HOWARD YOUNG		A i charact New	ral Cont	w.
	Sta Registr	_	JAN 3 0 2004	Bow &	Cook		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dev Physician Cathryn H. Hydzik 2004 21, 6PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Salisbury, Md. Wicomico Salisbury Rehab and Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex **Funeral** 1□ M 2X F Days Months Director 170-03-1182 89 10-4-1914 Pa. Usuel Residence of Decedent Pages 1 end 2 should be filled within 72 hours after death with the Maryland nent of Health end Mental Hygiene. Int: if Item 27 is marked other than "naturel", or items 23s or 28s-f show 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f sho must be notified at 1X Yes 2 □ No Funeral Director Md. Wicomico Salisbury 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 21804 USA 200 Civic Ave. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3XXWidowed 4 □ Divorced Year or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Register Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Quinn Soffel Peter Soffel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5611 Ball Rd. Wilmington, De. 19808 James Hydzik, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem. 1-26-04 Hurlock, Md. 22. Name and Address of Fecility
Short Funeral Home, Inc. 21. Signature of Funeral Service Licensee Thirt-a 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical CONGESTIVE HEART FAILURE TEAR **Examiner** Physician/Medical Examiner or Attending Physician: The law requires that tha death certificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2□No 1 ☐ Yes 2 ☐ No ours eftar death.

eral Director: After this certific filled in by tha funeral diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 12.0 029168 hrace-30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 3 2004

Hydzik

Cathryn H.

1346 S. Division St. Suite, Salisbury, Md. 21804

LLEN

32. Registrar's Signeture

		•	For State Registrar	State of Maryla		nent of Health and I cate of Death	Mental Hygien	4004	04142
			Decedent's Name (First, Middle, Las	1)	4		2. Date of Death	ay Yeer	3. Time of Death
	Physici /Medio		FRANK COL	UMBUS	HUTT		01 18	2004	1705 M
À-	Examir	er	4a. Fecility Name (If not institution, give	street and number)	4b	City, Town, or Location of Death	h 4	c. County of Death	2.5
	3		PEN/NSU/A REGIONAL 5. Social Security Number 6. Se	medical c	rs. last birthday) If	346/384/4 Under 1 Year   If Under 24 Hrs.	8. Date of Birth		ace (State or Foreign
20	Funeral Director			ZM 20F 70		onths Days Hours Min.	(Month, Dey, Yee	Count	M D
	D		Usuel Residence of Decedent						
	anylan show	L	10a. State 10b. County		City, Town or Location	()=		10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	ecto	10e. Street and Number	RSEI	PRINCE	SS HNNE Of. Zip Code		Citizen of What Coun	
	with the or 2	ă	150011	Land School	D.	21953	109.	115	A
	death	Funeral Director	113'14 - GREEN W.	12. Was Decedent Ever in	n U.S. 13. Was	Decedent of Hispanic Origin? (Ss, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - America	
စ္	or Ite		1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No I Yes, Give	, , , , ,	yes 2⊠No <i>Specity:</i>	o nicari, etc.)	Specify: R	BCK
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show with the Maxical Examinar must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates: 17K	my		100	Kind of Business/Inc	
15	in 72 i	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give kind	s Usual Occupation of work done during most of work NOT use retired)		Kind of Business/ind	ustry
2121	with jiene. r thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	HA	TCHERY	w	INSTON (-	DOUGE
	ould be filed with Mental Hygiene arked other tha attc event, the	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Maide	on Surname)	1
Maryland	should be nd Mental marked of umatic ev	၉	SAMUEL	HUTT		ANNAB		VENS F	UTT
Man	2 sho		19a. Informant's Name/Relationship (	11-	19b. Mailing Ad	idress (Street and Number or Re		7	1 . W 3-
	1 and Health em 27		20a. Method of Disposition	~ NEICE	b. Place of Disposition	-COLEGE T	Date 20c.	D Fam CESS Location - City or To	
nor	Pages nent of I int: If It		1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	cemetery, cremato	ry or other place)	24/04 Pa	Λ	UNE, MID
Baltimore,			21. Signatura of Euneral Service Licen			me and Address of Facility	3511115	SWITH F	711
ä	permit. Departimont import any inj	1	) Samuel -	4.	- 1917	- W. ISABELLA	ST. SAL	ISBURY, N	10,21801
			23a. Part1. Enter the disease, or shock, or heart failure. List only	olications that caused the done cause on each line.	eath. Do not enter th	e mode of dying, such as cardia	c or respiratory arrest,	10	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Resi	ovator	y Failure			Onset and Death
磁	/Medical Examiner		resulting in death)			· ·	~ .		
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):	ective Puln	Drung Di	SPERSO	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	All and a second		buse			
oʻ	exect an and rial-tra		resulting in death) Last	Due to (or as a con					
8760,	Attending Physician: The law requires that the death certificate be executed refath. sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		d					
9	entifica ling pl	Med	IF FEMALE:	22a Hunn automo el arri					
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time	etal death 3 Ect	apic pregnancy ner (specify)		23d. Date of delive Month	ry Day Year
P.O.	the de y the iched	yslo	1 Ures 2 No 9 Unknown	9 Unknown					
	ires that the death certifics signed by the attending pt d be detached for use as t	y Pl	Part II. Other significant conditions of				23e. Did tobacco	o use contribute to th	e cause of death?
ıds	w require been sig should b	edt	Hypertensi	on, Diak	petes M	ellitus	1 🗌 Yes	2 □ No 3 X Prob	ably 4 □Unknown
of Vital Records,	e law re has be je 2 sho	Completed by					24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of
H H	ysician: The last certificate hadirector, page	Con					performed?		2 🗆 No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	ath (Check only one)		
of	Phys r this ral dii	1: 70	1 ☐ Yes 2 ☒ No  27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	lome 5 ☐ Residence 28d. Describe how in		")
on	ding th: After	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Yee		Work? V 1 ☐ Yes 2 ☐ No			
Division	Attendi ar death. actor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp		factory, office	28f. Location (Street City or Town, Sta		l Route Number,
Ö	ital or irs aft rat Dii								
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical		niner: On the basis of exam		curred at the time, date and place gation, in my opinion, death occi			
	o the ithin 2 o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number	29d. C	Date signed (Month, i	Dey, Year)
)	F 3 F 8		11.1	1.11		26022	5 /	-19-20	04
	AVI		30. Name and address of person who	completed cause of death (	(Item 23a) (Type, Prin	t)	//	/	
	CA			HAMLETTE	m.s.	100 E. CAINI	1 51. 5A	UNBUM 1	N)
	St Regist	ate rar	31. Date filed (Month, Day, Year) 1	2004 32. Registrar's S	ignature	D6022 100 E. CA/WI/ Sporks			

214287607

fut Frank

		-	For State Registrar	State of Maryland /		rtment of H tificate of L			giene2 () Reg. No.	04	04:14:3
	Physicia		1. Decedent's Name (First, Middle, Last) ELVA JOYCE	HILDRETH				2. Date of Dead Month JANUAR	Y 16', 20	) <b>03</b> °	3. Time of Death 7:35 p M
>	/Medic Examin		4a. Fecility Name (If not institution, give s 914 Montrose Driv			4b. City, Town, or Salisb			4c. County Wicc	of Death	<del> </del>
	Funeral Director		Social Security Number 6. Sex		birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da February			tece (State or Foreign htty) Lryland
	and		Usuel Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation		-		1	0d. Inside City Limits
	Many	tor	Maryland Wicomic	o Sa	lisb	ury					1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	leath v	Funeral	914 Montrose Driv	12. Was Decedent Ever in U.S.	13. V	21804 Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No	USA - 14. Rac	e - Americ	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show says injury or other traumatic event, It a Medical Exatificat must be notified at Once.		1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	Amed Forces? 1  ☐ Yes 2 X No If Yes, Give Year or Dates:		Yes, specify Cuba	n, Mexican, Puerto	Hican, etc.)	Specify	ck, White,	hite
21215-0036	"natur	Completed by	15. Decedent's Edu (Specify only highest grade		(Give	lent's Usual Occupa kind of work done of OO NOT use retired	furing most of won	king	16b. Kind of Bu	usiness/Ind	dustry
27	d withir giene. rr than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler		,		Retail	Foo	đ
Maryland	be file stal Hys ad othe event.	Be	17. Father's Name (First, Middle, Last) Arthur G. Adkins				18. Mother's Nam Ruth	ne (First, Middle, Truitt	Maiden Suman	10)	
ary E	should nd Mer marke	ဥ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street a			er, City or Town,	State, Zip	Code)
	and 2 ealth a n 27 is		Peggy Lynch/daugh			4 Serman	Dr., Sno				Charles
Baltimore,	Pages 1 nent of Hi ant: If Iter ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donetion 5 ☐ Other (Specify)	Removal from State Will	etery, cren	sition (Name of natory or other place Cemetery	l l	Date	20c. Location - Willard	•	
Balt	permit. Departr Imports sny inj		21. Signature of Poneral Service License	ono-	7 22	Name and Address Holloway 501 Snow	Funeral Hill Rd.	Home Pro	ofession oury, MI	nal A. 218	ssociation 04
	Physician		23a. Part 1. Enter the disease, or compleshock, or heart faiture. List only or timmediate Cause (Final	ications that caused the death. In cause on each line.	Oo not ent	,	g, such as cardiac		rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen	ce of):	ny ny	-2000				Gyrs
K	LXdiffillici	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ea of):	0					
	scuted ind transit	amin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
8760,	cate be executed physician and the burial-transit	dical Examiner	rossing in soun, east	Due to (or as a consequen	CO OI).					_	
.O. Box 68	death certifi e attending   id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩6 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
<u>α</u>	S C 0	by	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.		obacco use cont		he cause of death?
Records,	e law has b	Completed						24a. Was autoj perfo	psy ormed?	Were auto prior to co death? 1  Yes	opsy findings available mpletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth	26. Place of Dea	1			
	Phys this al dii	on: To	27. Manner of Death  1. Matural 5 Pending	1   Inpatient 2   EH	Outpatier b. Time of Injury	28c. Injun	4   INGISING N		dence 6 Oth		(y)
Division of	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str		103 2 0 110	28f. Location ( City or To		er or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C		rsician: To the best of my knowle iner: On the basis of examination and memor stated							
	To the within 2 To the comple	Med	29b. Signature and title of confier		\	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
		(	30, Name and address of person who c	ompleted cause of death fitter 2	) Ba) (Tyne	Print	26278	}	/ -	-19	-04
DE	2		31. Date filed (Month, Day, Year)	2. Registrar's Signatur	CAI	Sparks	r. 5	A4584	17, W	0	7-04 71801
	St Regist	ate rar	JAN 2 1 20		19	Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** SOFIA **HERNANDEZ** 17, 2004 4c. County of Death /Medical 4b. City, Town, or Location of Deeth 6:25 AM 4a Facility Name (If not institution, give street and number) Examiner Salisbury Rehab & Nursing Center Salisbury Wicomico 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Yrs. Director 120-44-0679 94 January 14,1910 Cuba Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other than "naturel", or frems 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave Funeral 21804 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 🗷 Yes 2 🗆 No Specify: Cuban Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rafael Hernandez Chapple Paula Gessa 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelfa G. Balea/niece 623 Ridge Rd., Salisbury, MD 21801 permit. Peges 1 end Depertment of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial Park 1/20/04 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examine physician end the buriei-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) ettending pl for use es t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 LLHC 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Box 68760, Division of Vital Records, P.O. certificate hes been signed by the (lirector, pege 2 should be deteched or Attending Physician: the funeral director, After this death. efter death Director: filled in by

Baltimore, Maryland 21215-0020

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ٩ 1 Yes 2 No 4 ☐ Norsing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \tag{Homicide} within 24 hours e To the Funeral D completely filled 29a. Certifier Medical 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hin

State Registrar

31. Date filed (Month, Day, Year) JAN 2 1 2004

W-9 32. Registrar's Signature

end address of person who completed cause of death (Item 23a) (Type, Print)

1346 S. Division St. Salisbury, MD 21804 ouks

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

30. Nam d address of person who completed SUSM R. OMARA, MD

FEB 0 2 2004

31. Date filed (Month, Day, Year)

32. Rigistrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

R. OMARA, MD 11711 LIVINGSTON ROAD FORT WAS HINGTON, MD

Spert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend Item#24aperVERBALG8282/25/04 Coertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** LILLIAN MARIE HARMAN 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin <u>Worcester</u> If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F Yrs. 218-24-5638 Director 71 7/10/1932 MDUsuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examericants be a citified at 1 XYes 2 No MD Directo Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9961 Elm St. 21842 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. it. Pages 1 and 2 should be filed within 72 hours after riment of Health and Mental Hygiene. rrant: If item 27 is marked other than "natural, or Ite Armed Forces: 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ Specify: White 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Owner/Operator Motel 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roland James Taylor 2 Carrie Leona Mae Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Harman, Jr. 13408 Madison Ave. Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 XBuriat 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Evergreen Cemetery 1/24/04 Berlin, MD 21. Signature of Funeral Service License 22. Name and Address of Eacility Burbage Funeral Home The Burbage Fu

108 William St. Berlin, MD

23a. Part1. Enter the disease, for complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St. Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DZTIC mo. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): \-3\-6<sup>\c\</sup> O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Expired Records, F Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed? 1 ☐ Yes 2 ☐ No ५८३४ of Vital। 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ision 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) `∑ 4 | Homicide the Hospital 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 21811 2/Thury 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2004

20b. Plaze of Disposition Name of Disposition				1 - For State Registrar	State of Maryland		irtment of H tificate of I			ene20		04	147
Examinary  Examinary	1			1. Decedent's Name (First, Middle, Last)		,,					Voor	3. Time of	f Death
4. Excitation Adventists Hospital Takona Park Washington Adventists Hospital Takona Park User Iver Iver Interest Hospital Takona Park User Iver Iver Interest Hospital Takona Park User Iver Iver Interest Hospital Takona Park User Iver Iver Interest Hospital Takona Park User Iver Iver Interest Hospital Takona Park User Iver Interest Hospital User Iver Interest Iver Interest Hospital User Iver Interest Iver Iver Iver Iver Iver Iver Iver Iver				Edward William	Hutmire					25, 200		8:05	РМ
Source   S				4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of	f Death		
Symbol   S		#											
Tak case   Do Courty   Tak one				579 <b>-</b> 38 <b>-</b> 3617	M afte	,,,			(Month, Day,	rear)	Coun	itry)	
New York College   1.5		and w			10c Cib	/ Town or Lo	cation				1	Od Inside C	ity Limits
New York College   1.5		Aaryla   sho	ō								1		•
New York College   1.5		28a-1	ect		ery Ta	akoma			10	n Citizen of W	hat Cour	ntry?	
New York College   1.5		with the or									nat oour	,.	
New York College   1.5		leath	era		12. Was Decedent Ever in U.	S. 13. V			pecify Yes or No-		- Americ	an Indian,	
Holly Foley Daughter    Comparison of Deposition   Date	39	urs after o	by	1 Never Married 2 Married	1 XYes 2 No If Yes, Give	1	_		Rican, etc.)				
Holly Foley Daughter    Comparison of Deposition   Date	Õ	2 ho	ted			16a. Deced	ent's Usual Occupa	ation	10	6b. Kind of Bus	iness/Ind	dustry	
Holly Foley Daughter    Comparison of Deposition   Date	215	thin 7	ple			lite. L	OO NOT use retired	) )	ung				
Holly Foley Daughter    Comparison of Deposition   Date	2	ad will	Con			Cont	ract Ana	lyst	]	Departm	ent	of the	Navy
Holly Foley Daughter    Comparison of Deposition   Date	g	al Hy al Hy d oth	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Mi	aiden Sumame	)		
Holly Foley Daughter    Comparison of Deposition   Date	<u>a</u>	Ment Ment arked	2	Edward Henry H	Hutmire			Louise	Catherin	e Richa	ards	on	
200. Method of Deposition (Name of Deposition	a	2 sho and is m	11.7		·								
Physician (Medical Examiner)  Physic	2	and lealth m 27						rive, Si					
Physician (Medical Examiner)  Physic	0	T it of H	1	·	l no	ace of Dispos emetery, crem	sition (Name of natory or other plac	e) Jan	uary 31	Oc. Location - C	ity or To	wn, State	
Physician (Medical Examiner)  Physic	Ē	. Pa tmen tant:						tory 2	004 A			Virgi	nia
Physician / Medical Examiner  Physic	Bai	Depar Impor any ir			Cole							, MD 2	:0901
Physician   Micedical Examiner   Security				23a. Part1. Enter the disease, or domplie shock, or heart failure. List only on	cations that caused the death							Approximat	te
Part		Physician		Immediate Cause (Final disease or condition	CARNO	Pul na	WARY	ARRE	47				
Sequentially list conditions.  Sequentially list conditions.				resulting in death)	Due to (or as a consequ	ence of):	4	11/4-0	_ 43 /				
Due to (or as a consequence of):    Due to (or as a consequence of):		Examiner		Sequentially list conditions	PNEW	MOTE	/仕						
Due to (or as a consequence of):    Due to (or as a consequence of):		₽ ;	Iner	cause. Enter Underlying	Due to (or as a consequ	rance of):							
Section   Sect		ecute and trans	cam	that initiated events									
FFEMALE:   23b. Was deedednot pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   9   U	50,	cien a		Todaking in oodin, Edot	Due to (or as a consequ	ience or):							
FFEMALE:   23b. Was deedednot pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   9	87	physi	d	d									
9 Unknown 9 Unkn	9 ×	ding			3c. If yes, outcome of pregnar	nev				and Date	-1.4-1: -		
9 Unknown 9 Unkn	8	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3 🗌							Year
The state of the s		the de	ysic			ratii J	Other (specify)						
25. Was case referred to medical examiner?	٥.	that i	/ Ph	Part II. Other significant conditions con	tributing to death but not resu	ılting in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contrib	oute to th	e cause of c	death?
25. Was case referred to medical examiner?	g	uires I sign Id be							1 🗆 Yes	2 □ No 3	Prob	ably 4 🎮	Jnknown
25. Was case referred to medical examiner?	Ö	w req beer shou	lete						24a Was an	24h W	ere autor	osy findings	available
25. Was case referred to medical examiner?	Re	he la e has ige 2	duc						autopsy performe	pri ed? de	or to cor ath?	npletion of c	ause of
The street of th	a			25. Was case referred to medical				OC Diago of Days		No 1L	Yes	2 🗌 No	
The street of th		scert	00	examiner?	ospital: 1 Manatient 2 1	EB/Qutpatient	3 DOA Othe	ar		on 6 Mother	(Conside	-1	
building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	ō	p Phy er this eral c			28a. Date of Injury	28b. Time of	28c. Injury	at				/	
building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	0	nding th. r: Afte	atlo		(Month, Day Year)	Injury							
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (29b.  Vis	Atter	ifice	determined	28e. Place of Injury - At ho	me, farm, stre	et, factory, office	111111111111111111111111111111111111111	28f. Location (Stre	et and Number	or Rura	Route Num	iber,	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (29b. Signature and title of certifie	ā	s after Dir	Cert	4 Direction	building, etc. (Specify	/			City or Town,	State)			
		e Hospi 124 hour e Funera letely fills		(Check only 2 Medical Examir	Ier: On the basis of examinat	wledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and mani e and place, an	ner as st d due to	ated. the cause(s	;)
		To th within To th	Me	29b. Signature and title of certifier	A. 0		29c. License	number	290	I. Date signed	(Month, I	Day, Year)	
				1 Myral	g M()		109	16529	1	ArellA	RY	262	084
30, Name and address of person who completed cause of death (Item 23a) (Type, Print)		wi		30, Name and address of person who co	mpleted cause of death (Item	23a) (Type: F	Print)			.1 (~()1)	-1 -		
Discourse and address of person who completed cause of death (Item 23a) (Type, Print)  VICTOR ONEY CLIANA 73 25A HANGOVER PARKWAY GREETER ELT MARKA	1			VICTOR DreyE	LIAKA 732	SA H	AMOVER	- PARK	WAY GR	EGGBE	et T	MARY	(Aren
State Registrar JAN 2 8 2004 32. Registrar's Signature A Aparthal	65					ure &	Sporks	1					

			1 - For State Registrar	State of I	Marylan		artmen <i>tificat</i>				lental Hy	/giene	/ 1	004	0	148
	6		1. Decedent's Name (First, Middle, Las	t)							2. Date of D Month			· · · · · ·	3. Time of	Death
	Physici /Medio		Hannah Watso	n Ho	У						Janua	ry 22	Ž, :	2004	5:40	РМ
	Examir		4a. Facility Name (If not institution, give						Location	ol Death				ty of Death	·	
			Shady Grove Adven					kvil				Mo	ont	gomery		
я	Funeral		5. Social Security Number 6. Se 577-64-5470	x 7 □M 21XIF	Age (In yrs. 1	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D August	irth ay, Year,	210	9. Birthp	lace (State o	or Foreign
	Director		Usual Residence of Decedent			Yrs.		-			August 2	20, 1	913	Edinbu	rgh, Sc	otland
	land		10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside C	ity Limits
	Mary	jo	Maryland Prince Geo	rge's	Mitc	hellvi	11e									21 No
	28a	rec	10e. Street and Number				10f. Zip	Code				10a. Ci	tizen o	f What Cour	ntry?	
	3a or	ā	1220 Kings Tree D	rive			207							State	•	
	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23s or 28s-f show ent, the Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	.S. 13. \			spanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)		14. R	ace - Americ	an Indian,	
9	after or ite	Ē	1 ☐ Never Married 2 ☑ Married	Armed Force		i				i, Puerto	Rican, etc.)			ack, White,	etc.	
8	rel', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:		I ☐ Yes	2KI No	Specify:				Spec	whi	te	
2	72 h	Completed	15. Decedent's Ed (Specify only highest gra-			16a. Deced	lent's Usua kind of woi			t of work	ına	16b. K	(ind of	Business/Ind	dustry	
2	athin ne.	npi	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	e retired	)		··· <b>y</b>					
2	led w lygier her ti	S	12	-		Home	maker	:						Home		
ב	be fall H od ott	Be	17. Father's Name (First, Middle, Last) John Dodds								e (First, Middle					
3	Mer Merke Marke	은									Adams	-				
<u>a</u>	12 sh h and 7 is n		19a. Informant's Name/Relationship (7								al Route Numi					7.0
ď,	1 and fealth am 2		Andrew C. Hoy/ So  20a. Method of Disposition	<u>n</u>	20h P	LOII3			Grov	e Ro	ad, Ga:					/8
ğ	Pages ment of h ant: If its		1 ☐ Burial 2 【Cremation 3 ☐		te M	emetery crentonics on the control of	natory or of	ther place	θ) Ja	anuar	,	20c. L	ocation	- City or To	wn, State	
Baltimore, Maryland 21215-0036	rant rant		`4 □Donation 5 □ Other (Specify		Cre					5,20		Betl	nesc	la, Ma	ryland	1
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Extendent must be notified at once.		21. Signature of Funeral Service Licen		100689		Roc	:kvi]	Lle, J	Marv	ert A. West 1 land 20	J850 <b>-</b>	onre Jome -280	ey Fun ery Av 05	eral i	iome/
B			23a. Part En of the disease, or composite the composite composite the composite compos	lications that caus	ed the death	n. Do not ente	er the mode	e ol dying	g, such as	cardiac	or respiratory a	arrest,			Approximat Interval Bet	ween
8	Physician		Immediate Cause (Final disease or condition	. 41	2hein	ner's	Dom	enti	C.						Onset and I	
	/Medical Examiner		resulting in death)		as a consequ										4 00	
	LAMITHE		Sequentially list conditions,	b												
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):										
	ate be execu ed hysicien and the burial-transit	Exan iner	that initiated events resulting in death) Last	C. Due to (es.												
8760,	be ex clen ourial	E		Due to (or a	as a consequ	uence oi):								1		
	icate be execuled physicien and sithe burial-transit	dical		d										-		
9 ×		Physician/Med	IF FEMALE:	23c. If yes, outcon	no of orogon	201										
Box	eath certif attending for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic pre							ate of delive Ionth	*	Year
o.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown		eatn 5∟	Other (spe	өспу)							,	
م.	The law requires that the de tte has been signed by the a vage 2 should be detached i	Ph	Part II. Other significant conditions co	intributing to death	but not resu	ulting in the ur	deriving c	ausa dive	n in Part I		23a. Did	tobacco	use cor	ntribute to th	e cause of d	eath?
ds,	w requires that been signed should be det	d by	Dehydration	^		<b>y</b>	,,	g					_	3 ☐ Prob		
Ö	been	ete									·					
ě	has ye 2	Completed	Hypertension								24a. Was		24b	. Were autor prior to con death?	osy findings a npletion of c	available ause of
<u></u>											1 ☐ Yes	2 No			2 🗆 No	
Division of Vital Records,	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only					
ō	Phys this ral di	. To	1 Yes 2 No 27. Manner of Death	1 Zinpa 28a. Date of Ir		ER/Outpatien 28b. Time of		A	4 L Nu		me 5 Res				")	
L O	ding f h. After funera	tion	1 Telephantural 5 ☐ Pending	(Month, I	Day Year)	Injury	M 2	Bc. Injury Work	ai ? /es 2 🗀 i		28d. Describe	now inju	ry occu	irred		
S	or Attene after death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	niun, - At ho	ma larm str			92 2 1		28f. Location	(Strant or	a of Alcom	than an Duna	/ Dougla Alice	
<u> </u>	after of Direct	ertif	4 Homicide determined	building,	etc. (Specify	nne, rann, sin	eet, lactory	, опісе			City or To			ber or Rura	Houte Num	<i>561</i> ,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification of the funeral director, the funeral director, to be seen that the funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director.		29a. Certifier 1 Certifying Phy	/sician: To the he	st of my know	wledge death	Occurred :	at the tim	a data an	d place	and due to the	031100/-	\ and -	220004 22 -	atod	
	HO: 24 h	Medical	(Check only 2 Medical Exam	iner: On the basis and manner	or examinat	tion and/or inv	estigation,	in my op	inion, dea	th occurr	ed at the time.	date and	d place	, and due to	the cause(s	)
	within co	Me	29b. Signature and title of certifier				29c	License	number			29d. Da	te sign	ed (Month, L	Day, Year)	
	>		P. Coellahar	Lou	MA			0	4179	4		Jan	ua	ry 23,	2000	1
			30. Name and address of person who o	ompleted cause o	f death (Item	23a) (Type,	Print)				ithersb					•
	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signat	ture 4	1	/	· ,		110	0 /				
	Registr	ar	JAN 28 20	U4 A			1400	ans								

			1- For Amend Item#5,	per È	State o	6 Mar	ylang 15/2	d / Depa 004gap <i>Cer</i>	rtmen tificat	t of H e of L	ealth a	and M	lental Hy	/giene	2	004	. 01	: 149
			1. Decedent's Name (First, Middle	-									2. Date of D	eath			3. Time	of Death
	Physicia /Medic		Eli C. Hostetle	r									Month Janua	.ry 20		Year 2004	8:4	40 A M
	Examin		4a. Facility Name (If not institution	give str	eet and nu	mber)			4b. City,	Town, or	Location	of Death		4c.	Count	ty of Death		
			1620 Marshall A	venu	e				Rock	vill	.e			М	ont	gomer	У	
	Funeral		5- Social Security Number	6. Sex	/ 2□F	7. Age (I	In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	av. Year)		9. Birth	plece (State	or Foreign
	Director		<del>577-03-5781</del>	1 57 1	N 2□F		97	Yrs.					Dec. 1	9, 1	906	Indi		
1	g *		Usual Residence of Decedent  10a. State 10b. County			11	0c. City	, Town or Lo	cation								10d. Inside	City Limits
	sho sho	5																s 2 No
-	28a-1	Director	Maryland Montgo	nery			Kock	kville	10f. Zip	Code				10a Cit	izen of	f What Cou	intry?	
3	10 S		1620 Marshall A	70211	0					0851						State	•	
1	ns 23	Funeral	11. Marital Status		. Was Dec	edent Eve	er in U.S	S. 13. V				gin? (Sp	ectv Yes or N				ican Indian.	
	a la la la la la la la la la la la la la	표	1 Never Married 2 Marri		Armed Fo	orces?					n, Mexicar	i, Puerto	ecify Yes or N Rican, etc.)		Bla	ack, White	, etc.	
3	urs a	þ	3		If Yes, Gi	ve Dates:			I □ Yes	2X No	Specify:				Speci	ity: Wh	ite	
	z no	Completed	15. Decedent	's Educa	tion			16a. Deced	ient's Usua kind of wo	I Decupa	ation	t of work	ina	16b. K	ind of [	Business/li	ndustry	
	Med Med	ple	Elementary/Secondary (0-12)	i grade t	College (			life.	DO NOT u	e retired	)	I OF WORK	nig					
1	gen th	00	8					Elect	ricia	n				E1	ect	rical	-	
2	al Hy	Be (	17. Father's Name (First, Middle,	Last)							18. Mothe	er's Nam	e (First, Middl	e, Maiden	Suma	ime)		
3	Ment	0	Cornelius Hochs	tet1	er							Barb	ara	He	1mu	th		
9	and and is my		19a. Informant's Name/Relations						_	,			al Route Num					
	and eaith m 27 ner tr		Ward E. Hostetl	er/S	on						lace		ofton,	_				
5	O H H		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation	3 □Red	moval from	State	20b.PI Cato	ace of Dispo emetery, cren Of H	sition (Nar natory or c	ne of ther plac	e) :	Janu	ary 29,	20c. Lo	cation	ı - City or T	own, State	
	ment ant:		`4 Donation 5 Other (S				Ceme	eterv				200	)4	Silv	er	Sprin	ng, Ma	ryland
Dal	permil. Pages 1 and 2 should be filed within 72 hours after dearn with the maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service	Licensee	35		M01	1346 Ro	. Name ar CKVI CKVI	d Addres Lle, le,	Inc. Mary	Robe 300 Land	West 1 20850	Pump Monte	nre ome	y Fur ery A	neral venue	Home/
	hysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complica only one	cause on	caused the each line.			er the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,			Approximinterval B Onset and 1 Year	etween d Death
	/Medical		disease or condition resulting in death)	a.		(or as a c											1 164	
T.	Examiner		Sequentially list conditions.	b.														
-	sit s	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to	(or as a c	onsequ	ience of):										
	rate be executed thysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to	(or as a c	onseni	ience of):										
Š .	be eo	E		l	000 (0	(5) 45 4 5	onsoqu	101100 01).										
0	phys the	dical		d.														
<b>Y</b>	w requires that the death certifical been signed by the attending phashould be detached for use as t	Physician/Med	IF FEMALE:	230	c. If yes, ou	itcome of	orenna	ncv			,				004 0			
3	atten for u	lan	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 (	Fetal	death 3	Ectopic pi Other (sp							ate of delive Month	Day	Year
5	the d	yslo	1  Yes 2  No 9  Unknown		9□ Unkr		10 01 00	5au 5	J Other (sp	ouiy)								
	that ed by deta		Part II. Other significant condition	ns contr	buting to c	death but r	not resu	ulting in the u	nderlying o	ause give	en in Part I		23e. Did	tobacco u	ISO COI	ntribute to	the cause o	f death?
3	ures sign Id be	d by											1 🗆	Yes 2	No No	3 ☐ Pro	bably 4 [	Unknown
2	v req beer shou	Completed											24a. Wa	e 20	24h	Wara aut	opsy finding	se available
	has ge 2	dm											aut	opsy formed?	240	prior to co	ompletion o	cause of
0	n: The ficete r, pa		Of Manager - formed to madical											2 X №		1 🗆 Yes	2 No	
<b>=</b> :	certi	o Be	25. Was case referred to medical examiner?	Но	spital:			5B/0		Othe	ar.		h (Check only					
5	ding Physician: The lav h. Affer this certificete has funeral director, page 2	<b>-</b>	1 Yes 2 No 27. Manner of Death		28a. Date (Mor	Inpatient of Injury		ER/Outpatier 28b. Time of		/A	4   140	irsing Ho	me 5 X Res 28d. Describe	_			ity)	
5	ding h. Afte fune	tlor	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		(Mor	nth, Day Y	'ear)	Injury	м	8c. Injury Work	k? Yes 2 □	No			•			
	Attenoral death rector:	fica	3 Suicide 6 Could	not be	28e. Plac	e of Injury	- At ho	me, farm, str	eet, factor	, office			28f. Location	(Street an	d Num	nber or Rui	al Route N	umber,
5	s afte	Certification:	4 Homicide		build	ling, etc. (	Specify	"					City or 1	own, State	)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier 1 Certifyin (Check only one)	g Physic Examine	r: On the t	e best of a pasis of ea nner state	kaminat	wledge, deat tion and/or in	n occurred vestigation	at the tim , in my op	ne, date ar pinion, dea	nd place, ath occur	and due to the	e cause(s) e, date and	and m	nanner as e, and due	stated. to the cause	ə(s)
	Fo th Mithin Fo th	Me	29b. Signature and title of certifie						290	. License	e number			29d. Da	te sign	ned (Month	Day, Year	)
			· ac-	1-1	Lest	cl_	4	141	) D	0009	748			Janu	ary	y 20 <b>,</b>	2004	
	0		30. Name and address of person	who com	pleted cau	ise of dea	th (Item	23a) (Type	Print)									
			Alan Weinstock,						,	Sui	te 10	05,	Silver	Spri	ng.	MD 2	0902	
	Sta	ate	31. Date filed (Month, Day, Year)			Registrar's			1						٠,			
	Registr	rar	I JAN 28	ZUU4		Separe		D	200	Zeko	/							

			1 - For State Registrar	State	of Maryl		artment of rtificate of		d Mental Hyg	giene Reg. No. 20	04	04150
ı	Physici	an	1. Decedent's Name (First, Middle	e, Last)				A1	2. Date of Dea Month		Year 3.	. Time of Death
	/Medic	al	MILD 4a. Facility Name (If not institution			NKLEY	4h City Town	or Location of De	JAN.	24, 20 4c. County o		1:15 A <sup>M</sup>
,	Examin	er	MONTGOMERY		ŕ	'AL		NEY		,	GOMER	Y
4	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 1		yrs. last birthday,	If Under 1 Yea   Months   Day		lin. (Month, Da)			(State or Foreign
	Director		520-18-2274 Usual Residence of Decedent	101111	81	Yrs.			DEC. 20	1922	COLO	RADO
	death with the Maryland rms 23a or 28a-f show rmst be nutified at		10a. State 10b. County		10c	. City, Town or L	ocation					Inside City Limits
	8a-fs	Director		GOMERY				SPRING				1 X Yes 2 □ No
	with II	Dir	10e. Street and Number  14916 HYDR	US RD.			10f. Zip Code	0906		10g. Citizen of Wi	nat Country /	
	death	Funeral	11. Marital Status	12. Was E	ecedent Ever	n U.S. 13.			(Specify Yes or No- lerto Rican, etc.)		- American I	ndian,
20	or Ite	by Fu	1 Never Married 2 Married	ried 1 □ Ye If Yes.	es 2 <b>X</b> No Give		1 Yes 2 XN		rento riican, etc.)	Specify:		
-0036	tural is Ex		3 XWidowed 4 □ Divorced	Year of Year o	or Dates:	16a. Dece	edent's Usual Occ	upation		16b. Kind of Bus	WHI.	
2 2	hin 72 Bn "na Medis	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade complete	ed) e (1-4or 5+)	(Give	e kind of work don DO NOT use retii	e during most of t	working			•
Z	ygient ygient her tha		12				CLERK		Name / Circle & disdute	PUBLIS		co.
land	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 heath and Mental Hygiene 1 terms 23a or 28a-1 show item 27 is marked other than "natural", or liems 23a or 28a-1 show coper traumatic event, the Medical Examinar must be notified at	o Be	17. Father's Name (First, Middle,  LLOYD		ATHESON	ı			Name <i>(First, Middl</i> e, LUCILLE	KESSING		
ary	shoul and Me mark umati	F	19a. Informant's Name/Relations		ATHLOO		ing Address (Stree		Rural Route Numbe			de)
e, Ma	and 2 ealth a m 27 is		KATHRYN L. HI	NKLEY/DA				S RD., S	SILVER SPR			
HOLE	Pages 1		20a. Method of Disposition 1 Deurial 2 Cremation		I .	cemetery, cre	osition (Name of matory or other p		Date	20c. Location - C		
Бапп	permit. Pages Department of I Important: If ite any injury or or		* 4 □ Donation 5 □ Other (S		,	2	S CREMAT  2. Name and Add	ress of Facility	27–2004	RIVERDA		
n	Dep Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen	j. 1	M.M.CI	ramer	wall	C	HAMBERS	FUNERAL	HOME & CR	EMATORIU DALE, MD	M,P.A. ). 2073	37
	E		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications the	at caused the d						App	proximate erval Between set and Death
Ċ	Physician		Immediate Cause (Final disease or condition resulting in death)	a	1n	eumo	na				On	set and Death
	/Medical Examiner		Todaling in doday	Due	to (or as a con	sequence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due	to (or as a con	sequence of):						
	and transi	Examin	that initiated events resulting in death) Last	c	A- (							
8/60,	icate be executed physician and the burial-transit		Tooling in bodin, East	Doe	to (or as a con	sequence or);						
200	ificate g phys as the	edical		d				70.55.5 (15.5.5)				
Š	death certiff e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		⊒Ectopic pregnan	icy			of delivery	Wass
	the at thed fo	ysich	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		egnant at time nknown		Other (specify)			Mont	th Day	Year
ŗ	w requires that the death certifi been signed by the attending I should be detached for use as	y Ph	Part II. Other significant condition	ons contributing t	o death but not	resulting in the	underlying cause g	given in Part I.	23e. Did to	bacco use contrib	oute to the ca	ause of death?
ras	quires an sign	ed by	Tulmonan	7 Hr.	sperter	man			1 U Y	′es 2□No 3	3 🔲 Probably	Unknown
Hecords	law re as be	ompleted	Cengest	ere-H	eart	Fail	ure-		24a. Was autop	an 24b. W	ere autopsy ior to comple	findings available ition of cause of
	cate ha	Con	0						perfor		ath? Yes 2	No
VII	Physician: The law this certificate has b ral director, page 2 sl	o Be	25. Was case referred to medical examiner 1 Yes 2 No	Hospital.	npatient	2 🗌 ER/Outpatie	nt 3 DOA	ither	Death (Check only on g Home 5 \ Resid		(Spacifu)	
TO L	ng Phys ter this neral di	n: T	27 Manner of Death		ate of Injury Month, Day Yea	28b. Time o				ow injury occurred		
<u>o</u>	tendir leath. lor: Af the fu	catic	2 Accident investi 3 Suicide 6 Could	igation			M 1 {	☐Yes 2☐No	20)			
UIVISION	l or At after o Direct	Certification;	4 Homicide determ	ningd 286. Pl	ace of Injury - Audition of In	At home, larm, st ecify)	reet, factory, office	9	City or Tow	Street and Number m, State)	r or Hurai Ho	ute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier Certifyir (Check only 2 Medical one)	Examiner: On th	the best of my e basis of exan	knowledge, deal nination and/or in	th occurred at the ovestigation, in my	time, date and play opinion, death or	ace, and due to the occurred at the time, o	cause(s) and man date and place, ar	ner as stated nd due to the	l. cause(s)
	To the within To the	Med	29b. Signature and title of certifie		A .	n	29c. Lice	nse number		29d. Date signed	(Month, Day,	Year)
	4		▶ Wilkin	un J	· N	mole	Di	1528	5	January	24/	2004
_	-1		30. Name and address of person	la, 30	14 Un	Versit	Print) Blod	#113,	Silvers	sing, M	d 20	901
	Sta Registr		31. Date filed (Month, Day, Year)	2004	2. Registrar's S	ignature 6	Spark	N	T		,	,

			For State Registrar	State	of Maryla	and / Depa <i>Cei</i>		of Health <i>of Dea</i> t		lental Hy	giene Reg. No.	2001	04151
			1. Decedent's Name (First, Middle	, Last)	-					2. Date of De	aath Day	Yeer	3. Time of Death
	Physicia /Medic		Joan Hesselgess	er						Januar		, 2004	5:34 A M
	Examin	_	4a. Fecility Name (If not institution	-	umber)			own, or Location			4c.	County of Dea	th
			Holy Cross Ho					r Spri	_			ntgomer	J
	Funeral		5. Social Security Number 579-34-0018	6. Sex 1 ☐ M 2 ☐ F	7. Age (In ye	rs. last birthday) Yrs.	If Under 1 ' Months D	Days Hour	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da	av. Year)	9. Bin	thplece (Stete or Foreign puntry)
	Director	-	Usual Residence of Decedent	Λ	1 /2	+ ""				Feb. 5	, 19	29 Was	shington, DC
1	low iow		10a. State 10b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits
	a-f et	io	Maryland Montgo	mery	S	llver Sp	ring						1 ☐ Yes 2 X No
	or 28	ire	10e. Street and Number				10f. Zip Co	ode			10g. Citi	zen of What Co	ountry?
	23a	Funeral Directo	2109 Gatewood P	lace			2090	)3				SA	
	tems tems	une	11. Marital Status	Armed F		U.S. 13.	Was Deceden f Yes, specify	nt of Hispanic Cuban, Mexi	Origin? (Spe ican, Puerto	ecify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
20	rs affe	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	ed 1 Yes If Yes, G Year or			1⊡Yes 2X	No Spec	city:			Specify:	White
3	stura cal E		15. Decedent	's Education		16a. Deced	dent's Usual (	Occupation			16b. Ki	nd of Business	/Industry
213-003	uic g	ple	(Specify only highes Elementary/Secondary (0-12)	<del>-</del>	(1-4or 5+)	(Give	kind of work of DO NOT use	done during n retired)	nost of worki	ng			•
7	giene gritha	Completed		2 Yrs	S.	Homem	aker				0	wn Home	:
/land	al Hy d oth	Be (	17. Father's Name (First, Middle,							(First, Middle		Sumame)	
<u>y</u> a	Ment Ment arked	ို	Harold E. Haye							G. Cart			
Mar	permit. Pages 1 and 2 should be lied within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if tien 27 is marked other than "natural", or flems 23a or 28a-f show any Injury or other traumatic avent, the Modical Examiner must be notified at once.		19a. Informant's Name/Relationsl Patricia Mille		ter							, MD 20	
. je	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	2 Damousi from		. Place of Dispo cemetery, crer	sition (Name natory or othe	of er place)		Date	20c. Lo	cation - City or	Town, State
Saltimor	ant: H		'4 □Donation 5 □ Other (S)		Ga	ate Of H							ing, MD
	epartr epartr portr ny Inj nce.		21. Signature of Puneral Service	icensee /	-/				-			Funera	
u s	205 2 2		Jeran (	i W.	bri							r Sprin	g, MD 20904
	*		23a. Part1. Exter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de each line.	eath. Do not ent	er the mode o	of dying, s <i>u</i> ch	as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	hysician		tmmediate Cause (Final disease or condition resulting in death)	a	Pneum								
ią	/Medical Examiner		roodang ar oddan,	Due to	o (or as a cons	equence of):							
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a cons	equence of):				<del></del>			-
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events										
'n	exec an an rial-tr	Exa	resulting in death) Last	Due to	o (or as a cons	equence of):							
09/8	cate be executed physician and the burial-transit	dlcal		d									
٠	ing ph	0	IF FEMALE:	1000000	1852 - 3								-
ָם מס	death certific e attending I d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live	utcome of pred birth 2 F	etal death 3	Ectopic preg				2	23d. Date of del Month	livery Day Year
5	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□ Unki	gnant at time o nown	of death 5	Other (speci	ify)					
7	w requires that the death certifi been signed by the attending I should be detached for use as		Part II. Other significant condition	ns contributing to	death but not	esulting in the u	nderlving caus	se given in Pa	art I.	23e. Did	tobacco u	se contribute to	the cause of death?
as,	signi signi	d by	Exacerbation C			•	, ,	Ü		1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown
Records	law req as beer 2 shou	ete	Metastatic lun	g cancer						24a. Was	an	24b. Were au	utopsy findings available
Ž ,	The lav	Completed								auto		prior to death?	completion of cause of
		0	25. Was case referred to medical					26 Pt	lace of Death	1 Yes		1 L Yes	2 No
5	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 █️No	Hospital: 1 🖸	Inpatrent 2	☐ ER/Outpatien	t 3 DOA	Othor				5 ☐Other (Spe	cify)
ם י	ig Physical dispersal di	T;T	27. Manner of Death  1 Natural 5 Pendin	28a. Date	e of Injury onth, Day Year,	28b. Time of Injury	28c	. Injury at Work?		28d. Describe			
	endir sath. or: Af he fu	atic	2 Accident investig	ation		.,,,,	М	1 Tes 2	No				
DIVISION	r Att	Certification;	3 Suicide 6 Could r 4 Homicide determ	289. Plac	ce of Injury - A ding, etc. (Spe	t home, farm, str	eet, factory, o	office	1	28f. Location ( City or To			ural Route Number,
<b>-</b>	ours al		20- 2-4%	- Physic I									
:	To the Hospital or Attending Phymiting 4 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the and ma	ne best of my l basis of exam inner stated.	mowledge, death ination and/or in	occurred at vestigation, in	tne time, date i my opinion, d	and place, a death occurre	and due to the ed at the time,	date and	and manner as place, and due	stated. to the cause(s)
	vithin o the	Med	29b. Signature and title of certifier		/	)	29c. L	icense numb	er		29d. Dat	e signed (Mont	h, Day, Year)
	10		1/			on	1 D.	52261			Janı	uary 26	, 2004
	10		30. Name and address of person										
_			Alan R. Segal,	M.D. 151	7/Hugo	Cir. S	ilver	Spring	, MD 2	20906			
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 28		Registrar's Sig		Soar	161					

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland		artment of I			Reg. No.	2004	W 1 1 W 6
Physici /Medi	cal	Maylon Ray Ha	<del>-</del>		Ab City Town	or Location of Dea	Januar	y 22	2004	3. Time of Death 11:45 A M
Examir	ner	52 Rockcrest Circle  5. Social Security Number 6. Sex	е	ast birthday)	Rockvil	1e If Under 24 Hr	s. 8. Date of Birt	Mor	ntgomery 9. Birth	place (State or Foreign
Director		Usual Residence of Decedent	M 2□F 51	Yrs.	Months Days	Hours Mir	Oct. 16	y, Year) , 19	52 Alab	ama
the Maryla 28e-f show	Director	Maryland Montgomer  10e. Street and Number		Rockvi				10a. Citiz	ten of What Cou	10d. Inside City Limits 1   Yes 2 No  ntry?
3a or	0	52 Rockcrest Circl	.e		2085	51		-	ed Stat	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show singly or other traumatic event, the Medical Examinar must be notified at once.	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 1	4. Race - Americ Black, White, Specify: Whi	can Indian, etc.
thin 72 hou e. an "natura Wedital E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	orking	_	nd of Business/In	dustry Contracts
the filed will have the control of t	Be Con	17. Father's Name (First, Middle, Last)	4	Comput	er Consu	· · · · · · · · · · · · · · · · · · ·	ame (First, Middle,	Maiden :	Surname)	
should and Men	ြင	Maylon Ray Hayes,		105 14-35			Pauline D		T 0 T	
and 2 st lealth and m 27 Is n her traun		Darcy P. Hayes/Wif	e	404 I	Hull Plac	ce, Rocky	ille, Ma	ryla	nd 2085	2
Definition Pages 1 Department of Himportant: If Ites noy injury or oth		20a. Method of Disposition  1	emoval from State Poff	metery, cren k Memo	sition (Name of natory or other pla rial Gar	dens 20		Colum	ation · City or To bia, Tenne	ssee
Departition of the policy of t		21. Signature of Funeral Service License	M013	46 Ro	ckville, Rockv	Inc. 30 ille, Ma	0 West Mo ryland 20	ontgo 0850-	ohrey Fu omery Av -2805	neral Home enue,
Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	porte ci				rest,		Approximate Interval Between Onset and Death
death certificate be executed eath certificate be executed eattending physicien and defor use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ			<b>18.</b>				
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna.  1 Live birth 2 Fetal  4 Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	у		2	3d. Date of delive	ery Day Year
law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resu	ilting in the u	nderlying cause gr	ven in Part I.	T .	obacco us		he cause of death?
The law recate has bee	Completed						24a. Was autop perfor 1 \( \text{Yes}	rmed?		ppsy findings available impletion of cause of
Or VICAT Physician: This certificatel free free free free free free free fr	o Be	25. Was case referred to medical examiner?	ospital:		0		eath (Check only o			
tending Physical distributions of the funeral distributions of the this the funeral distributions of th	-	1 Xes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo	4 Nursing ry at rk? Yes 2 No	Home 5 Resid			(y)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str			28f. Location (5 City or Ton		Number or Rura	al Route Number,
he Hospit n 24 hour he Funere	edical	29a Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	ician: To the hest of my know ler: On the basis of examinat and manner stated.	wledge death ion and/or in	n sneumed at the ti vestigation, in my	opinion, death occ	curred at the time,	date and	and manner as a place, and due to	fatad. o the cause(s)
Within Comp	W	29b. Signature and title of certifier			29c. Licen	se number			signed (Month,	
<i>V</i> •		30. Name and address of person who con			•	#211 R			,	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure &	Source					

		•	1- For Amend Item #5 per The C829 and 22/	ppartment of Health and Me Certificate of Death	ental Hygie	ene2004	04153
	Discolati		1. Decedent's Name (First, Middle, Last)		2, Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	_	Sherwood L. Hufford, Sr.		January	27, 2004	0130 M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Death	1
			Laurelwood Care Center	Elkton		Cecil	
	Funeral Director		5. Social Security Number 206-12-1814 1□ M 2□ F 78 Yr	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Y Mar. 13	9. Birth Co.	nplace (State or Foreign untry) PA
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	f shc	ō	MD Cecil Elktor	า		i	1 Nes 2 No
	the 28a	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	untry?
	3a or		100 Laurel Drive	21921		USA	
	ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spec	ify Yes or No-	14. Race - Amer	
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Exart art must be inclified at	þ	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puèrto F	ican, etc.)	Specify: Wh:	
Ò	72 ho	ted	15. Decedent's Education 16a. C	ecedent's Usual Occupation Give kind of work done during most of workin	16	b. Kind of Business/l	ndustry
	e. Ben "r	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)	9		
2121	giene er th	Completed	12	Dairy Farmer		Agriculutu	re
2	a Hy a Hy a oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>Na</u>	should be and Mental marked o	၉	Horace Hufford	Mildred	Chaffee		
Maryland	2 sho and Is m	v (	1.1.1	Mailing Address (Street and Number or Rural			
	1 and 2 Health em 27			10 N. Duke St., Unit			
altimore,	S - E		cemetery	Disposition (Name of crematory or other place) Eagle Crematory 1-3	30-04	Leola, F	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of uneral Service License	22. Name and Address of Facility Edward Home, Inc., 86 Pine			
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Longa			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of				
	Examiner		Sequentially list conditions, b. Metcs to	Lic Prostate CA			
_	p =	ner	f any, leading to immediate eause. Enter Underlying Cause (Disease or injury	):			
ρ	ocute nd trans	Examiner	that initiated events c.				
Ŏ,	e exe		resulting in death) Last Due to (or as a consequence of	):			
68760,	ificate be executed g physician and as the burial-transit	dicai	d				
_	entific ding p	<b>a</b>	IF FEMALE: 23c. If yes, outcome of pregnancy			1	
Вох	ires that the death certif signed by the attending d be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 mopths?  1 Live birth 2 Fedal death	3 Ectopic pregnancy		23d. Date of deli	very Day Year
P.O.	the de	ysic	1  Yes 2 No 4 Pregnant at time of death 9  Unknown 9 Unknown	5 Other (specify)			
	that the by detac	モ	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	sign d be	d by		, ,	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 donknown
Ö	w require been si should I	ete			24a. Was an	24h Mara au	topou findingo quellablo
Il Records,	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Completed			autopsy performe	prior to c death?	topsy findings available ompletion of cause of
/ite	cian	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		-
of	Phys this al dir	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp			ce 6 Other (Spec	ify)
ŭ	ling F	jo i	1 Natural 5 Pending (Month, Day Year) Inj	ury Work?	3d. Describe how	injury occurred	
Sic	death death tor:	icat	2 Accident investigation 3 Suicide 6 Coul for be 280 Place of Injury At home farm	M 1 Yes 2 No	of Location (Ctro	et and Number or Ru	ral Pauta Alumbar
Division of Vital	or A after Direc in by	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, ractory, onice	City or Town,		rai noute ivamber,
	spital ours ours illed		29a. Certifier 15 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, at	nd due to the cau	se(s) and manner as	stated
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only one) 2// Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	ompl	Me	29b. Signature and the properties	29c. License number	290	. Date signed (Month	. Day, Year)
	F > F 0		1-4+an	D54073	70	1 JAN 04	
	8		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		<u>'</u>	
	0		ADION STONE NO BIT CHIE	172 172	ASTE Di	E 19726	_
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature  JAN 3 0 2004	naves!			

			For State Registrar	State of N	Maryland		artmen <i>tificat</i>			and M		jiene leg. No.	2001	04154
	Physici	an	1. Decedent's Name (First, Middle Edna Esther								2. Date of Dea Month	Day		3. Time of Death
,	/Medio Examin		Edna Esther  4a. Facility Name (If not institution	Happe give street and number	or)		4b. City,	Town, or	Location o		January		2004 County of Death	8:00 PM <sup>™</sup>
			Chester River					ster					Kent	
	Funeral Director		5. Social Security Number 138–36–2042	6. Sex 7. A 1 □ M 2 1 7 F	Age (In yrs. last 93	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Nov. 12	, Year)		nplace (State or Foreign untry) ryland
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	our or Lo	cation				.00. 12	<u> </u>	10,1,110	
	Maryla f ehov	o	MD. Queen	A										10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 286-	Directo	10e. Street and Number	Aline s	Sud1e	ersvi	10f. Zip	Code	-			10g. Citiz	zen of What Cou	A
	th with		2809 Sudlersvi	lle Road			21	.668					USA	
	er dea	Funerai	11. Marital Status	12. Was Deceder Armed Force	s?	13. \	Vas Deced f Yes, spec	lent of Hi	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	1	14. Race - Amer Black, White	
35	be filed within 72 hours after death with the Maryland Hygiene. d other than "neturel", or items 23a or 28e-f ehow event, the Madical Examination ust be matified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 € If Yes, Give Year or Dates	7		1□Yes	No X	Specify:				Specify:	hite
515-003	72 hou		15. Decedent (Specify only highes	's Education	1	6a. Deced	lent's Usua kind of wo	I Occupa	ition	of working	19	16b. Kir	nd of Business/l	
7	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	DO NOT us	e retired)	)	OI WOINII	·9			
Maryland 21	filed v Hygie other t	O) e	/th 17. Father's Name (First, Middle, I	Last)		Но	memak		18. Mothe	r's Name	(First, Middle.		Home	
<u>a</u>	e d la b	To Be	Samuel Walls								Leager		<i>Damano</i> ,	
a Z	2 should and Men Is marke eumetic	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address	(Street a				r, City or	Town, State, Zi	ip Code)
	is 1 and 2 should of Health and Mer item 27 Is marke other treumetic		Dorris Roland	.4					Clay		DE. 19			
altımore,	0		20a. Method of Disposition 1		te cem	etery, cren	sition (Nan natory or o	ther place	. 1	_			cation - City or T	
			<ul><li>4 □ Donation 5 □ Other (Sp</li><li>21. Signature of Funeral Service I</li></ul>		Crun		Ceme						pton, Ma	
B B	permit. Departr Importe any inj		1 Kick of	Halfarl		37	O Cyp	, ne ress	Stre	ein et,	& Newna Milling	ım Fi Eton	uneral 1 , Md. 21	Home, P.A. 1651
	Physician /Medical Examiner	ilner	23a. Pant1. Enter the dissesse, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flam, teaching to this product cause. Enter Underlying Cause. (Disease or injury	a. Due to (or a	ed the death. (	ce of):	er the mod	,			r respiratory arr		<	Approximate Interval Between Onset and Death
Box 68/60,	death certificate be executed e attending physicien and id for use as the burial-transit	//Medical Examin	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcom								,	3d. Date of deliv	(en)
Ö.	at the death by the atter rtached for u	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de at time of death		Ectopic pro Other (spe			-			Month	Day Year
ords, P.	The law requires that the late has been signed by the page 2 should be detache	by	Part II. Other significant condition	ns contributing to death	but not resultir	g in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	-	_	the cause of death?
		Completed									24a. Was a autops perform	sy	24b. Were autoprior to codeath?	oppy findings available ompletion of cause of
Z I	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only on		2557	
ö	ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of In (Month, L	njury 28	Outpatien b. Time of Injury		Bc. Injury Work	" 4 □ Nur at ? 'es 2 □ N	2	ne 5 Reside 8d. Describe ho		Other (Speci	(fy)
DIVIS	- 0	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 289. Place of I	Injury - At home etc. <i>(Specify)</i>	, farm, stre	eet, factory	, office		2	8f. Location (Si City or Town	reet and n, State)	Number or Rur	al Route Number,
	To the Hospitel o within 24 hours at To the Funerel Di completely filled in	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	Physician: To the best examiner: On the basis and manner	of examination	dge, death and/or inv	occurred a vestigation,	at the time in my op	e, date and inion, deat	place, a	nd due to the cod at the time, d	ause(s) a ate and	and manner as s place, and due t	stated. to the cause(s)
	Vith To T	Σ	29b. Signature and title of certifier	VP	100		290	License	number	/	2	9d. Date	signed (Month,	Day, Year)
'			20 Name as	1000	VIV,	) (7	J.	111	03			1/-	0/04	
			30. Name and address of person	who completed cause of	-11 1.1	a) (Type, is him	1	Are	, A	est.	Arm 1	nd	2162	3
	Sta Registr		31. Date filed (Month, Day, Year)	2 0 2004 Regi	ar's Signature	#	Sport	E						

				• •		tment of H		•	000	
			For Stete	State of Marylan					200	1 01 155
			Registrer		Certi	ficate of D	eath		g. No. 200	
			1. Decedent's Name (First, Middle, Las	) // ~	4			2. Date of DeathMonth	Dav Year	3. Time of Death
	Physicia /Medic		James Her	1ry /tras	ZIMI			Jayvary	17 200	4 0848AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or l	ocation of Deat	n	4c. County of De	ath
	Examin	٠.	Union Itospital of C	ecil County		EIKT	04		Cecil	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign Country)
	Director		219-18-7808	M <sup>2□</sup> F 84	Yrs.	Months Days	Hours with	8. Date of Birth (Month, Day, March 21	, 1919 Ma	aryland
-	3		Usual Residence of Decedent							
	ylan Mot		10a. State 10b. County	10c. City	y, Town or Loca	ition				10d. Inside City Limits
:	Marie S	tor	Maryland CEcil		Warwick					1 ☐ Yes 2 ☐ No
	1.28g	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	36.0	0	72 Church Road			219	112		USA	
i	be lied within /z nouts after death with the maryland lat Hygiene. Ital Hygiene. d other than "neturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of His	panic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
0	or to	Ξ	1 Never Married 2 Married	1 XYes 2 No If Yes, Give		Yes 25 No		o moun, oto.,	Specify: E	
500	nours after turel', or Ite	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WWI	Ε   ''	2 165 2 2 X 140	Spacity.		Specily.	olack
2	ical	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Decede	nt's Usual Occupat	tion	rkina 1	6b. Kind of Busines	s/Industry
<u> </u>	within 72 ene. than "nef he Medici	ple	Elementary/Secondary (0-12)	College (1-4or 5+)		nd of work done du O NOT use retired)	army most or no			
7	d wit	Ю	7		Linewo	rker			automotiv	/e
9	other vent,	Be	17. Father's Name (First, Middle, Last)			Į.		me (First, Middle, M.		
land		To E	Dan Higgins				Hester	Travis Hi	ggins	
<u> </u>	s 1 and 2 should f Health and Mer item 27 is marke othar treumatic	n 3	19a. Informant's Name/Relationship (					ıral Route Number,		
Z	and 2 lealth a m 27 is har tre	11 8	Lillian Higgins/Wi	.te	, 72 Ch	arch Road	d, Warwi	ck, Maryl	and 2191	2
	s 1 a		20a. Method of Disposition		Place of Disposi emetery, crema	tion (Name of story or other place	)	Date 2	0c. Location - City of	or Town, State
Ê	Page ento nt: # ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	aware Ve	eterans (	Cemetery	1/23/20	04 Bear	r, Delaware
Бант	permit. Pages Department of h Importent: if ite any injury or of once.		21. Signature of Funeral Service Licen	S88	22.	Name and Address	s of Facility			
ã	Ped of the page of		23a Jart 1. Enter the disease, or comshock, or heart failure. List only		FE	llows, He	elfenbei	n & Newna	m Funeral	Home, P.A.
			23a art1. Enter the disease, or com	olications that caused the deat	h. Do not enter	the mode of dying	, such as cardia	or respiratory arre	st,	Approximate Interval Between
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	10000	- D				
ľ	Physician /Medical		disease or condition resulting in death)	a toute	140 (avel	cal Lut	arction			6 horrs
	Examiner			a. Acute V  Due to (or as a conseq  b. Coroyany	derice oi).	1200 =				Not Kyowy
		<u></u>	Sequentially list conditions,	b. Due to (or as a conseq	wante off:	01/29	1 2		-	1 P 10004
	led sit	를	Sequentially list conditions, if any, leading to inner liate cause. Enter Underlying Cause (Disease or injury that initiated events							
	and al-tra	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a conseq	uence of):					
9	ite be executed iysician and he burial-transit	calE								
/89	cate phys			. d						
×	leath certificat attending phy I for use as the	₩	IF FEMALE:	23c. If yes, outcome of pregna	ancy				23d. Date of d	leliven
XOR	ath c atten	a	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3 □E	ctopic pregnancy Other (specify)			Month	Day Year
o.	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	94ti 5 🗆 (	Striet (specify)				
<u>.</u>	res that the de sign <b>e</b> d by the a I be detached f	P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the unc	fertving cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Ś	res t signe	þ	6		•			1 □ Ye	s 2□No 3 <b>%</b>	Probably 4 Dunknown
Records,	w require been si should b	Completed		_				-		
ပ္	e law has b je 2 sl	ğ	Metastatic 1	Postate Canc	er			24a. Was an autopsy	prior to	autopsy findings available o completion of cause of
T .	The ate h page	ĕ						perform 1 Yes 2	52-No 1 □ Ye	
Vital	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					ath (Check only one		
<b>&gt;</b>	Physic this co al dire	2	1 ☐ Yes 2 ZNo	Hospital: 1 Hopatient 2	ER/Outpatient			Home 5 Resider		pecify)
0	ding Pl I. After ti funera	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	w injury occurred	
Division of	auth. pr: Ai	atle	2 ☐ Accident investigation				′es 2 □No			
Ĕ	I or Attenc after death Director: I in by the	ţ	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	et, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
	italo rsaff elDi	Certification;						M.		
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1. Certifying Ph (Check only 2 Medicef Exer	ysician: To the best of my kno niner: On the basis of examina	owledge, death	occurred at the time	e, date and place	e, and due to the ca urred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	the H in 24 the F plete	Medical	one)	and manner stated.						
	To To E	Σ	29b. Signature and title of certifier	1		29c. License			d. Date signed (Mo	
			Myne as	un how		200	5519	0	Jenooly .	11,007
		1	30. Name and address of person who			rint)	-	treet E		27(=)1
_			Alfred A Pine	MD UMION	Hospi	tal 106	Bow S	treet E	IKton M	021921
	Sta	ate	31. Date filed (Month, Day, Year)	2004 32. Registrar's Signa		9				

State of Maryland / Department of Health and Mental Hygiene  $2 \, 0 \, 0 \, t_{
m L}$ Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year Physician January 24, 8:00 A M 2004 Robert Mac Hammond, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown Nursing & Rehab. Ctr. Chestertown Kent If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 25, 1 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** X M 2□ F 95 Iowa Director Aug. 444-05-0247 Usuef Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 √Yes 2 □ No Directo Salem. Pilesgrove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 08098 42 Birch Lane USA or Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: Specify Widowed 4 □ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welding Inspector 12 Texaco Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Thomas Carl Hammond Olive Mae Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Hammond, Jr. 42 Birch Lane. Piles rove, NJ. 08098 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/28/2004 Eglington Cemetery New Jersey \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Fellows, helfenbein & Newnam Funeral Home, 130 Speer Road Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between month on the Immediate Cause (Final disease or condition NeumoniA **Physician** resulting in death) /Médical HEART FAILURE ONTESTIVE Examiner Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed burial-transil the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy jo Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alan HEIMELS 23e. Did tobacco use contribute to the cause of death2 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an autopsy perform 2 No certificate 1 Tyes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 Tes Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 P Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit D36054 of death (Item 23a) (Type, Print) ATRICK SHAWAHAW SPEEN AN CHESTENTEN Md 21120 32. Registr /s Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:31P M **Physician** JANUARY 2004 ELIZABETH MAMIE JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 03/30/1908 9. Birthplace (State or Foreign Country Upper Jarlboro, MD 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 216-22-1012 95 Marlbořő, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at Prince George's Upper Marlboro 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10513 Broadleaf Drive 20774 U.S.A. or Itema 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 N Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental Hy I item 27 is marked oth Be Thomas Edward Butler Elizabeth Hattie Harley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) au. 10513 Broadleaf Drive
Upon Marlboro,
20b. Place of Disposition (Name of cometery, crematory or other place)
1/27/04 Elizabeth Geraldine Hudson/Dau. 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 1/27/04 ō Department of Important: If any injury or Clinton, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Henry S. Washington & Sons Co. Inc., 4925 Nannie H. Burroughs Avenue, N.E. Washington, DC 20019 21. Signature of Funeral Service Licensee permit. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequent **Examiner** onar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 menths? 1 ☐ Yes 2 ☐ No ĺ 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑No elluour 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 21X No Hospital or Attanding Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Nonpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 7525 Greenwan Center Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:00a M CECIL T. JACKSON January 18, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince Georges Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Washington DC Yrs. 577-62-0908 57 Director Debember 1, 1946 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f ehow 10a State 10b. County N☐Yes 2☐No Director MD Prince Georges Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral', or Items 23a or Exerciser must be r United States 125 69th ST 20743 filed within 72 hours after death Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Black 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 NDivorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Printer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be tment of Health and Mental tent: If item 27 is marked o Margaret Toomer Tracey Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 69th ST Capitol Heights, MD. 20743 LaJuana Jackson Bailey/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ft. Lincoln Cemetery 1 ☑ Burial ② Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 01/27/04 Brentwood, Maryland injury or permit. Page Department Importent: If 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy ST NW WDC 20011 21. Signature of Funeral Service Licensee any ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TNEUMONIA **Physician** /Medical Examiner LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18, 2004 1)0052865 JANUARY LA

State Registrar

DHMH 17 Rev 1/2001

3001 Hospital Drive, Cheverly Md. 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Michael Figaro

31. Para viled (Menth Dan Year)

			For State Registrar	State of	Marylan		artmen rtificat			ind Me		giene Reg. No.	20	04	0415	9
	Physicia	an	1. Decedent's Name (First, Middle, Last	)							2. Date of De.		200	Year 12	3. Time of Death 12:04p	vi
	/Medic	al	EMMA JOHNSON  4a. Facility Name (If not institution, give	street and num	nber)		4b. City.	Town, or	Location o		32111011111		County of		12.0.1	
	Examin		Holy Cross Hospita	_	,		,		pring			Mor	ntgor	nery		
	Funeral		Social Security Number     6. Se	x	7. Age (In yrs.	last birthday)		1 Year Days	If Under 2	24 Hrs.	8. Date of Bird	th V~Year)	029	9. Birthp	lace (State or Forei	חק
	Director		303-30-0131	□M 2□XF	65	Yrs.	I I I I I I I I I I I I I I I I I I I				Sept.	[2, ]	1938	Peni	isylvania	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limit	s
	Maryl -f sho	ξ	MD Montgom	ery	Silv	ver Sp	ring								1 XYes 2 □ N	0
	h the	irec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of W	hat Cour	itry?	
	ith wit	Funeral Director	3030 Hewitt Ave.	Apt. #	230			906				Jnite				
	tams	uner	11. Marital Status	Armed For		.S. 13.	Was Decea If Yes, spe	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	-		- Americ , White,	an Indian, etc.	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes If Yes, Give Year or Da	9		1 🗆 Yes	21XN0	Specify:				Specify:	B1	ack	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Id other than "natural", or Itams 23a or 28a-f show avant, the Medical Evarifier must be published at	ted I	15. Decedent's Ed	ucation		16a. Dece	dent's Usua	al Occupa	ition	t at warkin		16b. Ki	nd of Bus	siness/In	dustry	
212	hin 7: 9.	Completed	(Specify only highest grad	College (1	-4or 5+)	life.	DO NOT u	se retired)	u <i>ring</i> most	OF WORKIN	ig					
2	ygien yer th	Con	12th grade			Libr	ian		10 Motho	da Nama	(First, Middle,		ivat			
_	0 = 0 =	Be	17. Father's Name (First, Middle, Last)							a Gr		, Maideri	Suriame	*)		
Maryland	2 should be and Mental la marked o raumatic ava	ို	Edward Johnson 19a, Informant's Name/Relationship (7)	vpe, Print)		19b. Maili	ng Address	(Street a			Route Numbe	er, City o	r Town, S	State, Zip	Code)	
≅	nd 2 s lith ar 27 la rtrau		Donovan Keith John	son / S	Son	3030	Hewi	tt A	ve. A	pt#2	30 Sil	ver :	Spri	ng. I	MD. 20906	
ē,	of Health itam 27 other tr		20a. Method of Disposition		20b. F	Place of Disposemetery, crea					ate				wn, State	
Ē	Page nent c ant: If ury oi		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Gat	te of 1				/26/0					ng, Md.	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menit Important: If itam 27 Ia marked any injury or other traumatic a <u>once</u> .		21. Signat, re of Funeral Service Licen:	100 (C)	1						nson & DC 200		kins	Fun	eral HOme	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cane cause on ea	aused the deat ach line.										Approximate Interval Between	
2	Pnysician	χγ	Immediate Cause (Final disease or condition	Asyst	_										Onset and Death	
	/Medical Examiner		resulting in death)	Due to (	or as a conseq	uence of):										
П	_xaniine.	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Hear	t Fail	ure										
	uted I Insit	i i	Cause (Disease or injury	· ·	nary A		Disea	se								
o,	exectan and and rial-tra	Examiner	that initiated events resulting in death) Last	Due to (	or as a conseq	uence of):		-								
38760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physiclan/Medical		<sub>d.</sub> <u>Нур</u> е	rtensi	on										_
Вох 6	h certif ending use a	n/Me	23b. was decedent pregnant	23c. If yes, out	come of pregna		⊒Ectopic p	regnancy				:	23d. Date Mon		,	
0	that the death certific: ed by the attending pl detached for use as t	ysicle	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ant at time of d		Other (s						WOI	ui	Day Year	
P.O.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to de	ath but not res	sulting in the u	anderlying o	cause give	en in Part I.		23e. Did t	obacco u	se contri	bute to th	ne cause of death?	
rds	w require: been sig should b	ed b	Cerebro Vascular				_	_			1 🗆 '	Yes 2	□No	3 🗌 Prob	ably 4X∏Unknov	חי
ဝ၁	e law re has bee je 2 sho	Completed	Peripheral Vascul	ar Dise	ease						24a. Was	DSV	p	rior to co	psy findings availat mpletion of cause o	le
Œ Œ	Th ate pag	Con									perfo 1 ☐ Yes	ormed? 21☐ No	1	eath? □Yes	<b>2</b> ₹ No	
Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		(Check only o					
o	Attanding Phyaician: r death. actor: After this certific by the funeral director,	1.70	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🗆 1	npatient 21/2 of Injury th, Day Year)	ER/Outpatie 28b. Time of		28c. Injury Work	4 🗆 140		ne 5 Resi 28d. Describe				γ)	
on	ding th: Afte fune	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	1	h, Day Year)	Injury	м		(? Yes 2 🔲 I	No						
Division of Vital Records,	I or Attand after death Diractor:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	208. Flaue	of Injury - At h ng, etc. (Special	ome, farm, st	reet, factor	y, office		2	28f. Location ( City or To			er or Rura	I Route Number,	
	Hospita 4 hours Funaral ely fillec	edicai C	29a. Certifier 1 Certifying Ph	iner: On the ba												
	To tha I	Med	29b. Signature and title of certifier		1 0		29	c. License	number			29d. Dai	e signed	(Month,	Day, Year)	
	1/2/		> Iflour	e XI	Moo	n		D 5	766	91		1/	21	00	l	
	46		30. Name and address of person who Ghousia Sultana,	ompleted caus	e of death (Ites 2107 He	m 23a) (Type ritage	Print)	c Cir	cle,	Silv	er Spr	ing,	MD.	209	06	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 7 2004		egistrar's Sign											

Amend Item/19a,19b per Fun Dir State of Maryland / Department of Health and Mental Hygiene AACo. Health Dept. BEM 1/30/04 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Howard F. Jennings Jr. January 2004 21 2:45 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 105 W. Earleigh Heights Road Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 217-16-6845 79 Director June 14 1924 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental hygiene. Important: If Item 27 is marked other than "nature" any injury or other traumatic exceptions. 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ∰Yes 2 □ No Directo <u> Maryland Anne Arundel</u> Severna Park 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 105 W. Funeral Earleigh HeightsRoad 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ②No If Yes, Give 1 Yes 2₺ No Specify: Black Specify: \$ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Landscaper Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard F. Jennings Sr. Geneva Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 W. Farleigh Heights Road Severna Park, MD 21146 21108 19a, Informant's Name/Relationship (Type, Print, ALICIA A Jennings (WLIE) 20b. Plece of Disposition (Name of Commetery, crematory or other place)
Asbury Town Neck 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/27/04 Severna Park, Md Cemetery 22. Name and Address of Facility Church 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Zarry 100483 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. West 2 1 4 0 1 Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Medical Certification: To 27. Menper of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 2 Accident 5 Pending aftar death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) completely fillad in by 4 Homicide 24 hours e Hospital 29a, Certifier fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. within 2 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 2006 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 305 32. Registrar's Signatu 31. Date filed (Month State 2004 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Marylan		ent of Health ate of Death		ygiene,	2004 04161
	Physic /Medi		Decedent's Manne (First, Middle, Las	ones			2. Date of D Month	Death Day	Year 3. Time of Death
-	Exami Funeral Director		220-28-4938	Vursing Ho	me :	Sty, Town, or Location  Sulface 1 Year   If Under the Days Hours	bury	irth Day, Year)	Ocunity of Death  NOW CO  9. Birthplace (State or Foreign Country)  935 Maryland
9800	d within 72 hours after death with the Maryland jiene. rithan "natural", or Itams 23e or 28e-f ehow I're Medical Exeminer must be notified at	d by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County  Delaware  Sussex  10e. Street and Number  13409 Oak Branch  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	Deli  Road  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	10f. 1 S.   13. Was De If Yes, s	specify Cuban, Mexical	igin? (Specify Yes or N 1, Puerto Rican, etc.)	10g. Citiz USA	10d. Inside City Limits 1 □ Yes 2 ☑ No en of What Country?  4. Race - American Indian, Black, White, etc.  Specify: White
and 21215-0036	be file ital Hyg od othe event,	Be Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12) 11  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NO	work done during mos Tuse retired) e Designer	t of working or's Name (First, Middle	Furn	d of Business/Industry <u>siture Manufacturir</u> Sumame)
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Heelth and Mer Importent: If Item 27 is marke any injury or other traumatic <u>once</u> .	To	19a. Informant's Name/Relationship (7	ones (wife)  Removal from State  Dottonborent Spri	13409 Oa ace of Disposition (I ametery, crematory of Inchill Memo 22. Name HOLL	k Branch R Name of or other place) ory Carden and Address of Facilit OWAY Funer	January 23,200 al Home Pro	20c.Local	an Doman Town, State, Zip Code)  Laware 19940 ation - City or Town, State  From Maryland ional Association Maryland 21804
8760,	Physician and // Medical physician and // Physician and /	Ical Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b.  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	lode of dying, such as	cardiac or respiratory:	arrest,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica tle has been signed by the attending ph page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetel 4 Pregnant at time of dea	death 3 Ectopic			23	d. Date of delivery Month Day Year
ords, P.	w requires that the bear signed by should be deta	by	Part II. Other significant conditions co	ntributing to death but not resul	iting in the underlying	g cause given in Part I.		tobacco use	o contribute to the cause of death?
al Reco		Completed					24a. Was auto perfo 1 □ Yes	psy prmed2	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Division of Vital Records,	utending Physideath.	Certification; To Be	25. Was case referred to medical examiner?    Yes 2 No		R/Outpatient 3 28b. Time of Injury M	DOA Other: 4 Number 1 28c. Injury at Work?		dence 6 [ how injury of	Other (Specify) occurred  Number or Rural Route Number,
۵	To the Hospitel or Ai within 24 hours after or To the Funerel Directompletely filled in by	edical Cer	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinational manner stated.	ledge death occurre	ed at the time, date and on, in my opinion, deat	f place, and due to the	021120(0) 05	nd manner as stated. ace, and due to the cause(s)
~	To th within To th compl	Me	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who co			9c. License number			signed (Month, Day, Year)
Q	Sta Registr			32. Registrar's Signatu		4 91) 2180	4,	-	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Month **Physician** William Henry JACKSON 25, 2004 5:40 AM Jan /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Nursing and Rehab Center Salisbury, Md. If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) **U**X M 2□ F Days 213-22-5309 Months 76 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Haalth and Mantel Hygiene. Important: If Item 27 is marked other than "natural", or frems 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No **Funeral Director** Wicomico 10e. Street and Number 10ff Zip Code 10g. Citizen of What Country? 6/35 CATCH PENNY U.S. A 21856 12. Was Decedent Ever in U,S.
Armed Forces?
1. ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married Married Specify: BIACK Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Wells & College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) SANDY JACKSON Corbin JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6/35 CATCH PLANY Rd-DURNITED MD 2/856
Date 20c. Location - City or Town, State WIF Shirley JACKSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ò 131/04 Injury 4 ☐ Donation 5 ☐ Other (Specify) Apringhill Cometery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Benne 50014 W. Isabella St - Salisburg 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 3 months Examine Due to (or as a consequence of) by Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after daath.

To the Funeral Director: After this certificate has been sis completely filled in by the funeral director, page 2 should I Be Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? ensium 1 Yes 2€ No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2E No A⊟ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical ş 29c. License numbe 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B.Si Via, Jr. (NOW) 1346 S. Division St. Suite, Salisbury, Md. 21804

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 7 2004

32. Registrar's Signature

Physician /Medica Examine

**Funeral** Director

	Plea	se Type or	Print in	Black In	delib	le ink	. Ensu	ıre Al	l Copies	s Are	Legible	<b>)</b> .		
for State		State	of Marylar				lealth a		lental Hy		000	,	~ !	
Registra				Ce	runca	ile oi	Deam	1		Reg. N	0. 2 11 11	4	04	163
1. Decedent's	Name (First, Middl								2. Date of D Month	Da	,	ar	3. Time of	
		Madhusud		oshi					Januar	-	3, 2004		3:11	A <sup>M</sup>
alti		n, give street and nu			4b. Cit	y, Town, o	r Location	of Death		44	c. County of D	eeth		
		rsing Cen			ļ		ville	0.4.11			Montgo			
5. Social Sec	-	6. Sex 103tM 2□ F	7. Age (In yrs.	last birthday) Yrs.	Month	s Days	If Under Hours	Min.	8. Date of Bi (Month, D	ey, Yeer	)	Counti		r Foreign
217-02			70	113.			L	L	Oct. 3	, 19	933	Ind	ia	
10a. State	nce of Decedent 10b. County	,	10c. C	ity, Town or Lo	ocation							10	d. Inside Cit	ty Limits
Mary1a	nd Monte	omery		Ro	ckvi	110							1 🗆 Yes	2 ☑ No
10e. Street a				110		Zip Code				10a C	itizen of What	Count	n/2	
		C1			101. 2		- 0							
		Cherry Dr		10 100	) I	208		-1.0.10			nited S			
11. Marital St		Armed F		7.5.	If Yes, sp	pecify Cub	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	0-	Black, W			
	r Married 2 ☐ Mari wed 4 ☐ Divorced	If Yes, G	ve -		1 🖺 Yes	2 X No	Specify:	:			Specify: As	d an	_Indi	0.00
J CATAIGO			/al03.	169 0000	dent's 11	nual Coor	ation			166				तम
		nt's Education est grade completed)		16a. Dece (Give	kind of	work done work retire	durina mos	at of worki	ing	100.1	Kind of Busine	iss/indl	asu y	
Elementary	//Secondary (0-12)	College (		Econ			-/			Mor	ld Ban	b		
17 Father's	lame (First, Middle,	(ast) 5+		ECOII	OHITS	L	18. Moth	er's Name	e (First, Middle					
	ar Joshi	LEGI/												
					1				thi Dan					
	nt's Name/Relations								al Route Numb		•	. ,		
	1 M. Josh	i/Son					Cher		ive, R					20850
	of Disposition	3 □Removal from		Place of Dispo cemetery, cre	matory o	ame of r other pla	ce) J	anua	ry 25	20c. L	ocation - City	or Tow	m, State	
	ation 5 Other (S			ntgomery				2004	-	Bet	hesda,	Maı	ryland	i
21. Signatur	Funeral Service	Licensee		2:	2. Name	and Addre	ss of Facili	ty	Funera	1 11-	Bet	hes	da-Ch	evy
	af	Lare	M001	98 75	557 W:	iscon	sin A	ve I	Funera Betheso	la. N	me/ C 1D 2081	has 4-3	e, Ind 501	с.
23a, Pert1, I	nte the disease, or	r complications that t only one cause on	caused the dea	th. Do not en	ter the m	ode of dyir	ng, such as	cardiac c	or respiratory a	arrest,		1 1	Approximate Interval Betv	9
Immediate C	ause (Final			www. Fod	1								Onset and D	
disease or c resulting in c	eath)	a	spirato (or as a consex		Ture									
			ngestiv		t Fa	ilure	<b>.</b>							
Sequentially if any, leading	list conditions, g to immediate r Underlying	D	(or as a consec									-		-
Cause (Dise	ase or injury	<b>√</b> H∨	pertens	ion										
that initiated resulting in d		C	(or as a consec									-		
		Di	abetes											
		d										-		
IF FEMALE:		23c If yes ou	tcome of pregn	ancy							004 0-4(	4-15		
	cedent pregnant ast 12 months?	1 Live	oirth 2 Feta	al death 3		pregnancy	/				23d. Date of Month			'ear
1 ☐ Yes	2 □No	9□ Unkr	nant at time of o	Jeath 5	Other (	specпу) _								
		ons contributing to d	leath but not ro	culting in the c	n doch sin e		on in Bort I		23a Did	tobacco	use contribute	n to the	cause of de	eath?
	ial Fibri		eath but not res	sutting in the c	ındenyınıç	g cause giv	en in raiti	١.			_			
									-	Yes 2	MINO 3	PIODAI	bly 4 □U	INTOWN
Cer	ebro Vasc	ular Acci	dent						24a. Was		24b. Were	autops	sy findings a	available
										ormed?	death	? 'es 2		1036 01
25. Was case	e referred to medica	ıl					26. Place	of Death	(Check only					
examiner	? 25☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 I	DOA Oth	or		me 5□Res		6 DOther /S	peciful		
27. Manner o	f Death		of Injury oth, Day Year)	28b. Time o		28c. Injur	~ ~		28d. Describe			,		
1 ⊠Natu		19	nn, Day Year)	Injury	М		k? Yes 2 🗍							
3 🗍 Suic	ide 6 Could	not be	of Injury - At h	lome, farm. str					28f. Location	Street a	nd Number or	Rural	Route Numb	ber,
4 🗍 Horr	ncide determ		ing, etc. (Speci			,,			City or To					.,
29a. Certifier	157 Cartifuis	ng Physician: To the	hest of my ke	owledge deat	h occurre	ad at the to	ne date or	nd place o	and due to the	Cauca/-	l and manner	ac etc	led	
(Check o	only 2 Medical	Examiner: On the b	e best of my knowasis of examination	ation and/or in	vestigation	on, in my o	pinion, dea	id piace, a ith occurre	ed at the time.	date an	d place, and c	as stat	ted. he cause(s)	
	re and title of certifie		nioi stateu.		9	9c. Licens	e number			29d Da	ite signed (Mo	onth D	ev Year)	
, acco. orginally					1 6					marg. 6/6	GIRLION (MIL	or the fa but	~ y , . was /	

State

31. Date filed (Month, Day, Year)

JAN 28 2004 Registrar

Vetti T. Anthony,

M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19500 Amaranth Drive, Suite B, Germantown, Maryland 20874 oaks

D0051158

January 23, 2004

			Please	Type or Prin State of Ma		Indelible Inlepartment of				ole.
			1 - State Registrar			ertificate of			Reg. No.	04 04 161
ì	Phỳsic /Medi		1. Decedent's Name (First, Middle, Las	cobs				2. Date of De Month	Day 2 2	Yeer 2:34 PM
<i>y</i>	Exami		4a. Fecility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County	
		м	Howard Canf	Gereal	Hapital	Colu	mbig		Hou	se D
	Funeral Director		5. Social Security Number 6.547 - 50 - 2034	ex 7. Age □M 2∏XF	e (In yrs. last birtho 88 Yrs	Months Dave		8. Date of Bir (Month, Da	th ix, Year)	9. Birthplace (State or Foreig Country) South Caroli
			Usual Residence of Decedent		00	"		Sept.	16, 1915	South Caroli
	how		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Ma	cto	Maryland Prince Ge	eorge	Laure1					1X□Yes 2□No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	s 23	era	7705 Hyacinth Cou			20707			United	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medicial Exercises in the Provided at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:		<ol> <li>Was Decedent of If Yes, specify Cul</li> <li>Yes 2 No</li> </ol>		pecify Yes or No o Rican, etc.)	- 14. Race Black Specify:	- American Indian, k, White, etc. Black
	in 72 ho "natura fedical I	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(G	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	ipation of during most of wor	king	16b. Kind of Bus	siness/Industry
	filed withi Hygiene. other than	E O	Elementary/Secondary (0-12)	College (1-4or 54	+)	omestic	<i>30)</i>		Priva	ate
	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame	
, mar. j mar.	should be nd Mental marked o umatic eve	10	Jacob Geiger				Isabel1	Bought	night	
	2 shc and ls m		19a. Informant's Name/Relationship (T			ailing Address (Stree				State, Zip Code)
î	1 and Health em 27 ither tr		Daranita Wiggins/ 20a. Method of Disposition	granddaugh		2 Lee Pla	ce, Carit	ol Heigh		20743
	mit: I ite	1	1 ☐ Burial 2 X Cremation 3 ☐I	Removal from State	cemetery, c	sposition (Name of crematory or other pla		Date		City or Town, State
		1	* 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service 1/201	1	Chesape	ake Cremat 22. Name and Addre				
	permit. Departr Importa any inji		Rehad hom		-		rgia Ave.			
	9		23a. Part I. Enter the disease or comp	lications that caused t	the death. Do not a					Approximate
F	hysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line	).	,	•	, <b>-</b>		Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	consequence of):					5 days
	Examiner		Sequentially list conditions	b. Pres	monis					- Jan S
	isit ed	Examiner	Sequentially list conditions, if any second to me adata cause. Enter Underlying Cause (Disease or injury	Dividito (or as a	consequence of);					
	oe executician and purial-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
		<u>a</u>								
	death centificate attending phys d for use as the	Physician/Medic		0.						
	endin use	M/W	Edd. 1120 docodoni pregnant	23c. If yes, outcome of 1☐Live birth 2		. □ E			23d. Date	of delivery
	9 00 0	sicie	in the past 12 months? 1 Tyes 2 No	4 Pregnant at til		B Ectopic pregnancy Control of the c	y 		Month	
	ed by the detached	Phy	9 Unknown							
	as been signed by th 2 should be detache	by	Part II. Other significant conditions col	ntributing to death but	not resulting in the	underlying cause giv	en in Part I.			ute to the cause of death?
	neen hould	etec	19656 Pyocarxiol	- intere	t, Con	Sionyon	sathy	1 Y	es 2 □ No 3	☐ Probably 4 ☐ Unknown
doing. The le	has l	Completed	Hnemis Adult	Viespira	tung 6	Jutiess	- 5. Janlen	24a. Was a autops	sy pric	re autopsy findings available or to completion of cause of
F	certificate rector, pag		Jehry Tration S	epotic .	Stock			perform 1 Yes		ath? Yes 2⊒No
	is certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2000	oot 3D DOA Oth	26. Place of Deat		110.5	
6	h. After this funeral o	P 6	27. Manner of Death	1 Impatient 28a. Date of Injury	28b. Time	of 28c. Injur	v at		ence 6 Other	
100	ath. e fun	atlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Day )	rear) Injury		k? Yes 2□No		,,,,,	
. 844	irecto irecto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, s	street, factory, office		28f. Location (St. City or Town	reet and Number	or Rural Route Number,
legic	urs af			4					·	
1	within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director, it	edical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Exemin	sician: To the best of a	Adminiation and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
4	o the		29b. Signature and title of certifier	and manner state	d.	29c. Licens				
F	3		1 2-4		KI	250. Licensi	/ / ~	25	9d. Date signed (#	100
	2	-	30. Name and address of person who co	empleted cause of dea	th (Item 23a) /Tuny	Print)	6/20		Jan Z	2, 2004
			F De Leon	10724 L	ttle A	7) //	Kung Co	Lumbia	Ma	7. ( 8) 41.
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	1	1,00	10-614	- ''	-1079
	Registra	ar .	JAN 2 9 20	U4 Dene	va 5	Soork	2.0			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Otate of	Maryiai		rtificate of		мептат нус	leg. No. 2 (	ากเ	16165
	Physic	ian	1. Decedent's Name		•				-	2. Date of Dea Month	199	Year	3. Time of Death
	/Medi			ERNARD JA		SR.				January	22 2	2004	10:35
-	Exami	ner	4a Facility Name (II WASHINGT)						4b. City, Town, or TAKOMA	Location of Death		y of Death GOMERY	7
	Funeral Director		5. Social Security No. 579 – 54 – 37		Sex IZM 2□F	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1941	9. Birthpli Count WASHI	ace (State or Foreign TNGTON D.C.
	pur *	•	Usual Residence of 10a. Stete	Decedent 10b. County		10c Ci	ty, Town or Lo	eation				1.0	od Incide On It is
	Manyta f sho	ō	MD.	MONTGOME	ERY		VER SP					10	od. Inside City Limits  1
	28a	5	10e. Street and Num					10f. Zip Code		1	0g. Citizen of	What Count	
	3a or	<u>ie</u>	1517 MEN	LEE DRIV	Ξ			20904			USA		.,,
215-0020	within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner mast be motified at	Be Completed by Funeral Director	11. Marital Stetus 1 ☐ Never Marrie 3 ☐ Widowed		12. Was Dece Armed For 1 XYes If Yes, Give Year or Da	ces? 2 □ No		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2√ No		Specify Yes or No- to Rican, etc.)	Bla	ca - America ck, White, e y: BLAC	itc.
20	72 ho	ted	(Special	15. Decedent's Ed	ducation		16a. Deced	lent's Usual Occup	pation	4.2-	16b. Kind of B	usiness/Indu	ustry
21	ithin 7	nple	Elementary/Secon	ify only highest gra ndary (0-12)	College (1-	4or 5+)	life. I	kind of work done OO NOT use retire	d) most of wo	rking			
121	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the M	S			2		DISPA	TCH MANAG			PEPCO/		IES
Maryland	ould be fii Mental H arked ott	Be	17. Father's Name (							me (First, Middle, M		ne)	
Ž	hould d Mei marke	T <sub>o</sub>	ROBERT CL				10h Mailie	- Add (Ct		E WALKER		a =: .	
Z			ALVIN B.							ural Route Number LVER SPR			iode)
Baltimore,	Peges 1 and nent of Health int: if frem 27 iry or other to		20a. Method of Disp				Place of Dispo	sition (Name of natory or other place	-		20c. Location		m, State
Ë	mit. Pegesartment of cortaint: If is cortaint: If is cortaint. If is cortain or the cortain or t		4 Donation	5 Other (Specify	y)		TE OF	HEAVEN CI	EMETERY 1	/28/04	SILVER	SPRIN	IG,MD.
Bal	permit. Peges Department of Important: If is any Injury or BRGE.		21. Signature of Fun	eral Service Licen	S <del>00</del>	>				SEPH GAWL			
The state of the s	Physician		23a. Part1. Enter the shock, or heart	disease, or comi railure. List only	plications that ca one cause on ea	used the deat ch line.	h. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (F disease or condition resulting in death)	inal	a. He	net	ٺ	Ence	= Obal up	ath_		1	8 clar 3
		-	, , ,		_	Due to (c	r es a conseq	Eve	\	0			9
	ficate be executed physician and sthe buriel-transit	Examiner	0		b. E~	210 1 41	es e conseq	10cf C	11 Sears	e		Y	Luly
oʻ	an an niel-tn		Sequentially list confidency, leeding to immoduse. Enter Under Couse (Disease or in that initiated events	nediate Ving		Dag 10 (0	es e conseq	uerice oi).				1	
68760,	tificate be executed ig physician and es the buriel-transit	edical	Ceuse (Disease or in thet initiated events resulting in death) Le	กุ่มกั	o. <u>Ca</u>	Due to (o	as a consequ	uence of):					jews
	± 5, 9	/Med	resulting in death) E	351	d								,
Вох	eath cert attendin I for use	Physician/M	D-411 Att										
P.O.	that the dended by the a	hysi	Part II. Other signific	ant conditions co			uiting in the un	derlying cause giv	en in Part I.	23b. Did to	/		the cause of death?
	s thet med t	by P	Ken	11	su Il	-ייפופ-	*			1 1	s 2 XNo	3 Proba	ably 4 ☐ Unknown
Division of Vital Records,	The law requires thet the death cer ate hes been signed by the attendir page 2 should be deteched for use	Completed b					2			24a. Was ar perform		avail	e eutopsy findings able prior to pletion of cause aath?
<u>=</u>		5								1 □ Ye	s 2 No	10	Yes 2□ No
Vita	ician: The certificate rector, pay	Be	25. Was case referre examiner?	-	Heapital. •			Lou		th (Check only one	9)		
n of		on: To	1 ☐ Yes 2 ☐ N 27. Manner of Deeth 1 ☐ Natural	5 □ Pending	Hospitel: 1 XIng 28a. Date of (Month,		ER/Outpatient 28b. Time of Injury	3□ DOA Oth	4 LI Nursing H	ome 5 Reside 28d. Describe ho			
Sio	Attending or death. ector: After by the fune	catic	2 Accident	investigation					Yes 2 □ No				
Divi	tel or Attending Physis efter death.  I Director: After this ed in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place o	f Injury - At ho j, etc. <i>(Specif</i> y	me, farm, stre	et, factory, office		28f. Location (Str City or Town		er or Rural F	Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 (Check only 2 one)	Certifying Phy	rsician: To the bas iner: On the bas and manne	is of examinat	vledge, death ion and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the ca rred at the time, da	use(s) and ma te and place, a	nner es stat and due to th	ed. ne cause(s)
	Tot Com	Σ	29b. Signature and ti	tle of certifier	13			29c. License		29	d. Date signed	(Month, Da	ıy, Year)
	V		1/	n J./	Jean	_	WD.	DOO	42151	20	1/24	104	
			30. Name and addres	E 3	-	of death (Item		Print) Wesy	poledust	CLAI	نو:	_	
200	y w _a.		31. Date filed (Month)		earch 32 Bac	istar's Signa	7600	Car	rell V	tie.	TURC	m F	rk,m
	Sta Registr	re.		N 2 8 200		parar a Signal	9	Sparks					

		•	1 = For State Registrar	State of Maryland		artment of I rtificate of		ınd Men		giene Reg. No.		04	56
			Decedent's Name (First, Middle, Las.	")					Date of Dea Month	ath Day	Year	3. Time of Dea	th
	Physicia /Medic		Agnes Delores J	ordan					NUARY		2004	10:08 a	М
>	Examin		4a. Fecility Name (If not institution, give			4b. City, Town,	or Location o	of Death		4c.	County of Deat	h	
			St. Mary's Hospit			Leonardt					. Mary'		_
	Funeral		5. Social Security Number 6. Se	x 7. Age ( <i>In yr</i> s. <i>Ia</i> □ M 2 <b>N</b> F 8		If Under 1 Year Months Days		Min. (	Date of Birt Month, Day	h y, Year)	9. Birti	nplace (State or For untry)	eign
	Director		220-16-4708 Usuel Residence of Decedent	0.	7 113.			Au	gust	2./,	1918 Ma	ryland	
	land w		10a. State 10b. County	10c. City,	Town or Lo	ocation						10d. Inside City Lin	nits
	Many -1 sh	ō	Maryland St. Mary	's Mech	anics	ville						1 Tes 2	No
	1 the	rec	10e. Street and Number	B THECH	anres	10f. Zip Code	1			10g. Citi	zen of What Co	untry?	
	h with	Funeral Director	26203 Loveville R	oad		2065	59			USA			
	deet	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of If Yes, specify Cub	Hispanic Orig	gin? (Specify , Puerto Rica	Yes or No-	- 1	<ol> <li>Race - Ame Black, White</li> </ol>		
ထ္	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No					Specify: Bla	ck	
Š	be filed within 72 hours after deeth with the Maryland lat hygiene. Id other then "natural", or items 23e or 28e-f ehow event. Ite Medical Examinar must be mailified at	d by	3 Midowed 4 □ Divorced		16a Dana	de ette Heuel Ocea	ention				nd of Business/		
ν.	na r	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	ident's Usual Occu is kind of work done DO NOT use retire	ipation a during most ed)	t of working		100. NI	ng or business/	industry	
2	withir ene. then	щć	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	-,			0	wn Home		
0 0	Hygi Hygi other		8th 17. Father's Name (First, Middle, Last)		HOM	Cmarce	18. Mothe	r's Name (Fil	rst, Middle,				
a	ld be ental ked c	To Be	Francis E. Banki	ns			Chr	istine	Grey				
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental County, the Ment		19a. Informant's Name/Relationship (7			ing Address (Stree							
	alth a		Elizabeth Bankins	/Daughter-in-l	aw 2	6203 Love	eville	Road,	Mech			MD 20659	<del>)</del> —
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. ance.		20a. Method of Disposition		ace of Dispo metery, cre	osition (Name of matory or other pla	ace)	Date		20c. Lo	cation - City or	Town, State	
Ē	Pages nent of I ant: If Its ury or o		1. Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	) Que		Peace					n, Mary		
a	permit. Departn Imports any inju		21. Signatur of Funeral Service Licen	See MANILA		2. Name and Addr							
m	88 2 2 8	0 1	11/au K1330	14101114		2955 Hol					own, MD		
\$°			23a. Part1. Enter the disease, or compositions and shock, or hear failure. Ust only	dications that caused the death. one cause on each line.	. Do not en	ter the mode of dy	ing, such as	cardiac or res	spiratory ar	rest,		Approximate Interval Between Onset and Deatl	
	Physician	Ĥ	Immediate Cause (Final disease or condition	Kichen	tzi	June						2415	
	/Medical Examiner		resulting in death)	Due to or as a consequ	ence of):	1.1							
	LAdiminer		Sequentially list conditions.	b. Due to (or as a conseque	5 €	Kich	45						
	be at	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bus to (orlas a cyrisoda	61100 OI).								
	xecut and	xan	that initiated events resulting in death) Last	c Due to (or as a consequence	ence of):								
760,	ate be executed hysician and he burial-transit	calE		d									
687	ficate g physics the			· · · · · · · · · · · · · · · · · · ·									
Вох	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy	75				1	23d. Date of deli	•	
m	death e atte d for	Icia	in the past 12 months? 1 🗆 Yes 2 🗸 No	1 Live birth 2 Fetal		□Ectopic pregnand □ Other <i>(specify)</i> _					Month	Day Year	
0	t the by th	hys	9 🗆 Unknows V	9 Unknown							750		
S, D	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by P	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the t	underlying cause g	iven in Part I.	.			1	the cause of death	
g	w require been si should !								1 🗆 \	res 2	No 3 Pr	obably 4 □Unkn	OWII
Records,	law ra as be 2 sh	Completed							24a. Was autop	Sy	prior to d	topsy findings avail completion of cause	able of
		Š							perto	rmed? 2₩ No	death?	2 🗆 No	
Vital	Attending Physician: The law r death. ector: After this certificate has I by the funeral director, page 2 s	Be (	25. Was case referred to medical examiner?					of Death (CI	heck only o	ne)			
× ×	Physic this co	2	1 Yes 2 No		R/Outpatie	III 30 DOX					6 □Other (Spec	city)	
ū	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	28b. Time o Injury	We	uryat ork? ]Yes 2∐I		Describe h	now injur	y occurred		
Sid	tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	1	mo larm et				Location (S	Street an	d Number or Ru	ıral Route Number,	
Division of	i gite	Certification:	4 Homicide determined	building, etc. (Specify,	)	ileet, lactory, office	,	201.	City or Tox				
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier **Certifying Ph	ysician: To the best of my know	viedge, dea	th occurred at the	time, date an	d place, and	due to the	cause(s)	and manner as	stated.	
	24 hr 24 hr 3 Fun etely	edical		iner: On the basis of examinati and manner stated.									
	To the within 2 To the complet	₩	29b. Signature and title of certifier	7 1		29c. Licer	nse number			29d. Dat	e signed (Monti	h, Day, Year)	
	MA		1 /m /2	Ser L		Door	0050	(0		11	19/04		
7	140		30. Name and address of person who	completed cause of death (Item	23a) (Type			4			. 1 - 1		
			LEON BERUBE M.D.				anicsv	ville M	1d. 2	20659	9		
	Sta	ite	31. Date liled (Month, Day, Year)										
k.	Regist	ar	JAIN Z	1 2004 Dagger	A. The	Small 1							

J. T. M. J. AGNES DELORES JORDAN

				State of M	iaryian	•			Death	менан пу	Reg. No.2	04	041	6.7
	Di i . i		1. Decedent's Name (First, Middle, La	st)						2. Date of De	eath Day	Year	3. Time of De	eath
н	Physicia /Medic		Mary Lee Jester							January	7 16. 20	004	8:47P	M
	Examin		4a Fecility Neme (If not institution, giv					3	4b. City, Town, or	Location of Deat				
			William Hill Manc				If I lado	r 1 Year	Easto		Talb		1	r
	Funeral Director			M 2 F	ge ( <i>I</i> n <i>yrs.</i> 78	last birthday) Yrs.	Months		Hours Min		Tn, Year) 7,1925	9. Birthp Coun Mary]	olece (State or F otry) and	-oreign
	pue &		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City	Limits
	Meryl 1 ehc	ខ្	Maryland Queen	Anne's	S	Sudlers	vill	e					1 X Yes 2	2 □ No
	128 128	8	10e. Street end Number				10f. Zip	p Code			10g. Citizen of	What Cour	ntry?	
	h with	Funeral Director	133 West Main Str	eet			2	1668			USA			
	deat	ner	11. Marital Status	12. Was Decedent	Ever in U	,S. 13. V			lispanic Origin? (S en, Mexican, Puer	Specify Yes or No		ce - Americ		
21215-0036	filed within 72 hours efter death with the Merylend Hygiene. ther than "naturel", or theme 23e or 28e-f show ther the Medical Examinat Frust be notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give △ Year or Dates:	No				Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		v whi		
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest gra	ducation ide completed)		16a. Deced	lent's Usu kind of wo	al Occup	netion during most of wo d)	rking	16b. Kind of B	usiness/Ind	dustry	
21	within ene.	d d	Elementary/Secondary (0-12)	College (1-4or	5+)	_								
2	be filed withintel Hygiene. Ind other than event, the H		12+ 17. Fether's Neme (First, Middle, Last,	1		Insu	rance	e Ag		me (First, Middle	Insura			
anc	S is o	Be	John Richard Mand						Mary D		, maioon comer	,,,,		
2	s 1 end 2 should be f Heelth end Menteil tem 27 la marked of other traumatic eve	ဥ	19a. Informant's Neme/Relationship (			19b. Mailin	a Addres	s (Street	and Number or R		er, City or Town	, State, Zip	Code)	
Σ	end 2 selth en 27 la er trau		Howard Jester	,,,,,,,					treet Su					
ē,	f Hee	-1	20a. Method of Disposition		20b. P	Place of Dispo- cemetery, cren				Date	20c. Location			
Baltimore, Maryland	permit. Peges 1 e Department of He Important: If Item eny Injury or othe		1 <sup>4</sup> Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		<b>?</b>	ıdlersv				1/23/200	Vi Sud1	orowi	110 MD	
ati	mit. Personant: vinjury	1	21. Signature of Funeral Service Licer			22	. Name ar	nd Addre	ss of Facility					
m	Den grand		Kil Sig	Telkent	Zeen	) Fe	11ow	s, H	elfenbei s St. Mi	n, & New	mam Fun	eral	Home PA	A
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause	d the deat	h. Do not ente	er the mod	de of dyir	ng, such as cardia	c or respiratory a	irrest,	100	Approximate Interval Betwe	een
	Physician		SHOCK, OF HEAR FAILURE. LIST OTHY	one cause on each								1	Onset and De	ath
	/Medical Examiner	Н	Immediate Cause (Final disease or condition	. Pr	e U	non	io						week	5
	Examine	_	resulting in death)	0 (	Due to (c	or es a conseq	uence of)	:				1	weck Years	
	bed sit	Examiner	_	b. C+	10							- 1	Years	`
	ifficete be executed g physicien end es the burial-trensit	xar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0	Due to (o	or as e conseq	uence of):	:				1	Trace	-
68760,	slcier s buri	edical	Cause (Disease or injury that initiated events	56 .	Pue to lo	r as a consequ	mence of).	,					llar	>
89	g phy es the		resulting in death) Last		D00 10 (0	as a consequ	uence or.	•				1		
Вох	eeth certifi ettending   I for use es	Physician/M		d										
-	deeti e ette ed for	Sicie	Part tl. Other significant conditions of	ontributing to death	but not resi	ulting in the ur	nderlying	cause giv	ren in Part I.	23b. Did	tobacco use co	ntribute to	the cause of	death?
P.0	The lew requires thet the death certite hes been signed by the ettendingege 2 should be deteched for use	Phy	PUD							1/2	Yes 2□ No	3 Prof	bably 4 🗆 Ur	nknown
S,	es the	2	1 11									7		
of Vital Records,	w require been sign	Completed	HTN							24a. Was	an autopsy ormed?	240	<ul> <li>autopsy fine ilable prior to mpletion of cau</li> </ul>	_
ec	hes by	npje	112		A = .	- / .	)				. /	71	mpletion of cau death?	
표			Ullnary	70000	Nice	70				10	Yus 2 0	1[	☐Yes 2☐No	Ю
Zi:	Physician: The rthis certificete	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or /	ath (Check only				
5		은	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpat	1	ER/Outpatien 28b. Time of		UA	4 Linursing I	Home 5 Res	dence 6 LiOth how injury occur		r)	
0	ding h. After fune	盲	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Marth, D.	ay Year)	Injury	м	28c. Injur Wor 1 □	rk? Yes 2∐No					
Division	Attending or deeth. actor: After by the fune	fica	3 Suicide 6 Could not b	28e. Place of Ir			eet, factor	y, office			Street and Numi	ber or Rura	I Route Numbe	er,
Ö	s afte il Dira	Certification:	4 Homicide	building, e	tc. (Specif	<b>y</b> )				Ony or To	wn, State)			
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral			ysician. To the best niner: On the basis of										
	the H tin 24 the Fi	ledicai	one)	and manner s		STORE BETWEEN								
	Vith Con	Σ	29b. Signature and title of certifier				29	c. Licens	e number	. 1	29d. Date signe	ia (Month,	Day, rear)	
			Stu		-			100	03319	$\nu$	1121	) (0'	-1	_
			30. Neme end en ress of person who					1 -		ile.	1 04 65			
			Dr. Kathryn D. J 31. Date filed (Month, Day, Year)		M.D fer's Signa		Jynwo	od L	orive, Ea	ston, M	d. 21601			
	Sta Registra		IAN 2.3		rers Signa	K	Lane	18.0						

DHMH 16 Rev 6/95

ORIGINAL

			1 - For Registrar	State of Ma	arylan		artment of I				gien Reg. N	- 21111	4 04	168
	<u> </u>		Decedent's Name (First, Middle, Last)							2. Date of De	ath Da	av Year	3. Time o	of Death
	Physici: /Medic		HYMAN			KRAIS	EL				Y 22	2, 2004	2:30	A M
k ,	Examin		4a. Fecility Name (If not institution, give str	reet and number)			4b. City, Town,			_	40	c. County of Dea		
	e de la composition della comp		5. Social Security Number 6. Sex	7 Age	a /In vrs	last birthday)	If Under 1 Year		CVILL 24 Hrs.		th		TGOMER'	
	Funeral Director			M 2□F	92	Yrs.	Months Days		Min.	8. Date of Bir (Month, Da 9/25/1	911	WAS	rthplace (Stete country) HINGTO	N, DC
Episodi)	- Sedificaci		Usual Residence of Decedent											
	arylan	_	MARYLAND MONTGOMER	V		y, Town or Lo	ocation						10d. Inside (	s 212 No
	ith the Marylan or 28a-f ehow ne notified at	Director		L	DEK	MOOD	104 7:- Codo			1	100.0	itizen of What C		-A
	a or 2	2	10e. Street and Number				10f. Zip Code	855			iog. O			
	death with the Maryland ma 23a or 28a-f ehow	Funeral	600 GRANDLEY ROAD  11. Marital Status	. Was Decedent	Ever in U.	S. 13.	Was Decedent of	Hispanic Ori	igin? (Spe	cify Yes or No	p-	U.S.A	erican Indian,	
	or Itar		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	o ARI		If Yes, specify Cub 1 ☐ Yes 2 XNo	an, Mexican	1, Риепо Р	Hican, etc.)		Black, Wh	ite, etc. HITE	
3	172 hours after death w *naturel*, or Itema 23a idical Exertitive count t	d by	3 Widowed 4 Divorced	Year or Dates:	WW:	TT						-6-1-7		
<u>.</u>	natu edica	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	t of working	ng	16b. I	Kind of Business	s/Industry	
7	within iene. then	duic	Elementary/Secondary (0-12)	College (1-4or 5	+)		H MANAGE:	,			BAN	NKING		
2	Hyg Hyg ther ant,	a	17. Father's Name (First, Middle, Last)		-			7	er's Name	(First, Middle	-			
0	should be nd Mental marked c	ToB	SAMUEL KRAISEL					ZIPE	WERT	Z				
	2 should and Men is marke sumatic	•	19a. Informant's Name/Relationship (Type				ng Address (Stree							20006
	and tealth m 27		HEIDI CHANDONNET/DA	UGHIEK	20h P		COACHLA	MD LAN		ate		ocation - City o		20900
_	Pages nent of the first of the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	0	emetery, cre	matory or other pla					LS CHUR		RGTNTA
altimol	permit. Pages 1 and 2 should be Department of Health and Ments important: If Item 27 is marked any Injury 9c other traumatic once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licenses</li> </ul>	)	1111						1111	ILD OHOL	, v 1.	TO III
ם מ	Depo impo		(anthing)			N 7	ATIONAL Addr. 482 LEE	FUNERA HIGHWA	AL HO	ME ALLS Cl	HURC	CH, VIRG	INIA 2	22042
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused	the deat								Approxima Interval Be	etween
ı	Physician		Immediate Cause (Final disease or condition			TRUCTI	VE PULMO	NARY D	ISEA	SE			YEARS	Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):								
	Examine	-	Sequentially list conditions, b.	Due to (or as	20000	uence of):								
	pet list	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a conseq	201100 017.								
_	executed an and rial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a conseq	uence of):	***************************************							
6	pri pri	edical	<b>€</b> d.											
0	certificate nding phys use as the		IF FEMALE:							·				
ZOD DOX	death ce ne attendi ad for use	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome	2 Feta	I death 3	Ectopic pregnanc	у			1	23d. Date of de Month	olivery Day	Year
	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	time of d	eath 5[	Other (specify)							
ŗ.	w requires that the death certifica been signed by the attending pl should be detached for use as t		Part II. Other significant conditions conti	nbuting to death bi	ut not res	ulting in the u	inderlying cause gi	ven in Part I		23e. Did t	obacco	use contribute t	o the cause of	death?
2	quires n sign ald be	ed by	HYPERTENTION			,				1 🔀	Yes 2	2 □ No 3 □ P	robably 4	]Unknown
ecoras	law rec as bee 2 shou	plete	CORONARY ARTERY DIS	EASE						24a. Was		24b. Were a	utopsy finding	s available
ב	The law ate has page 2:	Completed	RHUMATOID ARTHRITIS							perfo	rmed? 2⊿N	death? o 1 ☐ Ye	s 2 No	02000
NI G	Physician: The ribis certificate har al director, page	Be (	25. Was case referred to medical examiner?							(Check only			Hogs	DT OF
5	는 근목	ဥ	1 ☐ Yes 2 🛣 No			ER/Outpatie				ne 5 🗆 Resi		6 Other (Spe	ecify) HOSI	PICE
	ding I h. After funer	tlon	1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Da)	Yeer)	Injury	Wo	ork? ]Yes 2.□		ou. Describe	now and	ary occurred		
DIVISION	Atten r deat ector: by the	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At ho	me, farm, st	reet, factory, office		2	8f. Location (		nd Number or F	ural Route Nu	m <i>ber</i> ,
5	s afte	Cert	4 Homicide	building, etc	c. ( <i>ap<del>u</del>cii</i> ,	r)				Oily of 10	wii, Stat			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Exemine	cien: To the best of	of my kno examina	wledge, deat	h occurred at the to	me, date an opinion, dea	nd place, a	and due to the	cause(s	s) and manner and place, and du	s stated. e to the cause	(s)
	the hin 24	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licen	se number			29d. Di	ate signed (Mon	th. Dev. Year)	
)	2 2 2 3		E. C.	Zib	ė	LA		9470				JARY 22,		
	10		30. Name and address of person who com	pleted cause of d	eath (Iten	1 23a) (Type	Print)							
_			EUGENE P. LIBRE, MD	. 10400	CON	NECTIC	UT AVE,	KENSIN	IGTON	, MARY	LAND	20855		
	Sta Registi		31. Date filed (Month, Pay, Year) JAN 28 200	32. Registra	ar's Signa	ture &	Spark	2						

			Tor State Registrar	State of Marylar			of Health and of Death	nd Mental Hy	giene Reg. No.	$Z \coprod \coprod U$	04169
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Helen Hoffman Ko	rab			<u>-</u>	January			4:00 A <sup>M</sup>
1	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	m, or Location of D	Death	4c.	County of Death	
Н			Suburban Hospital			Bethes				ntgomer	У
	Funeral		5. Social Security Number 6. Sex	M OF F		If Under 1 Y		Min. (Month, Da	iy, Year)	9. Birthr	place (State or Foreign
P	Director		147-32-4237	M 22 F 87	Yrs.			July 2	, 19	16 Mary	land
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	10d. Inside City Limits
	Aaryl Feho	٥	Manual and Manual and		-i+b	haras					1 X Yes 2 □ No
	28a-	ect	Maryland   Montgome	Ly Ga	ithers	10f. Zip Coo	de		10g. Citi	zen of What Cou	ntry?
	with 3a or	۵	419 Russell Avenue	a Δnt 210		20877	7		Unit	ed State	c
	within 72 hours after death with the Maryland ene. than "naturst", or itsms 23e or 28e-f ehow the Medical Exame her must be notified at	Funeral Directo		2. Was Decedent Ever in U	J.S. 13.	Was Decedent	ot Hispanic Origin	? (Specify Yes or No		14. Race - Americ	can Indian,
0	riter of	Fur	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No				Puerto Rican, etc.)		Black, White,	etc.
<u> </u>	esl', o	by	3 Widowed 4 Divorced	It Yes, Give Year or Dates:		1 □ Yes 2 <b>½</b>	No Specify:			Specify: Whi	te
ဂ္ဂ	72 ho natur ilcal	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual O	one during most of	f working	16b. Ki	nd of Business/In	dustry
2	thin 19.	n de	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	etired)		_		
7	filed w Hygier other th	Co		5	Te	acher	10 14-11-1-	Name (Fire Middle	_	ducation	·
<u>n</u>	tal H d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden	Sumame)	
<u>\{ \} \</u>	should be and Mental I	9	Arthur Schlossnag					Ault	0	. T	2-41
Maryland 21215-0036	C1 10 = 00		19a. Informant's Name/Relationship (Type					or Rural Route Numb			
	1 and Health em 27 ther tr		Arnold Korab/ Husb			Russell sition (Name o		Apt. 210		ithersbu cation - City or To	
Baltimore,	Pages I		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or other	<sup>rplace)</sup> ∤Ja	nuary 27			
	tant:		'4 □Donation 5 □ Other (Specify)			Cemete		004	Pil	es rove.	NJ neral Home/
a a	permit. Departr Importa any inju		21. Signatur & Euneral Service License		Be	ethesda	-Chevy Cl	hase, Inc. Land 2081	755		isin Avenue
	40264		23a. Part1. Enter the disease, or complic		1803	Bethes	da, Mary	land 20814	-350	1	Approximate
,09/	Physician / Medical Examiner prize p	ical Examiner	disease or condition resulting in death)  Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						unknown
O. Box 68	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XINo 9 □ Unknown	3c. If yes, outcome ot pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time ot 9 □ Unknown	al death 3	□Ectopic pregn □ Other (specif			2	23d. Date of delive Month	ery Day Year
Records, P	uires that signed b	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause	e given in Part I.		obacco u Yes 21		he cause of death? pably 4 Unknown
Ö	w requir been si should	Completed						24a. Was	an	24b. Were auto	ppsy findings available
ĕ	ne tav has ge 2	Ę							med?	death?	impletion of cause of
	ician: Th certificate ector, pag	e Co	25. Was case referred to medical				OC Disease	1 ☐ Yes Death (Check only	21X No	1 Tes	2 No
Ξ	sicis certi	8	avaminar?	ospital: 1 K Inpatient 2	TER/Outpaties	nt 3 DOA	Other	ng Home 5 ☐ Resi		3 □Other (Specif	5/1
O	Phy r this ral d	To	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c.	Injury at	28d. Describe			<i>y</i> /
0	ding Ith.	t lor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ No				
Division of Vital	l or Attending Physicisn: The after death.  Director; After this certificate hid in by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec		reet, tactory, of	fice	28t. Location ( City or To		d Number or Rura )	al Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical C	29a. Certifier  (Check only one)  12 Certifying Physical Call Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the	ne time, date and p my opinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	vithin o th	Me	29b. Signature and title of our fier			29c. Li	cense number		29d. Dat	e signed (Month,	Day, Year)
	->-0		1 ( retiral alex	Howemp			D59871	5	Janu	ary 22,	2004
	10		30. Name and address of person who co		m 23a) (Type.	Print)	-				
			Cristin Parker How				ter Drive	e, Rockvil	le,	Maryland	1 20850
44	y Sta	ite		32. Registrar's Sign	ature /	0				-	
	Regist		JAN 28 200	4 Seneva	Ø	space	K				

			1 - For State Registrar	State of M	arylar		artmen				•	giene Reg. No	2001	. 04	171
			1. Decedent's Name (First, Middle, Las	t)			<del></del>				2. Date of De	ath		3. Time o	of Death
	Physici /Medio		Michael Patrio	k Kiley	7						Januar Januar	<sub>Da</sub> у 24	y Yea • 2004		РМ
	Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		4c.	County of De	eath	
			Frederick Memori	1				deri					rederi		
ı	Funeral Director		034 32 0374	9X 7. Aq	61	last birthday) Yrs.	If Under Months	1 Year _ Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 11		•	lirthplace (State Country) W York	or Foreign
	and * .		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside (	City Limits
	f sho	ō	Md. Montgon	ery		ney									s 2 <b>X</b> No
	28e	rec	10e. Street and Number				10f. Zip	Code			Т	10a. Cit	izen of What	Country?	
	h with	Funeral Director	4209 Sandcastle L	ane				208	32			Uni	ted St	ates	
	deat deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13. \	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ar	nerican Indian,	
ထ္ထ	or Ite		1 ☐ Never Married 2 📉 Married	1 ☐ Yes 2 🔀			1 □ Yes 2		Specify:	i, Fuelto	nican, etc.)		Black, WI		
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:									Specify: W		
21215-0036	n 72	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		16a. Deced	dent's Usua <i>kind of wor</i> DO NDT us	l Occupa k done d e retired	tion <i>uring m</i> osi	t of worki	ng		ind of Busines		- F
12	withi iene. than	шо	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	Health							Agricu	artment Lture	OI
b	other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,			Louic	
<u>a</u>	uld be Aenta rrked tic ex	To B	Joseph Kiley						Kat	hryn	Mulque	en			
Maryland	and halls ma		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City o	r Town, State	, Zip Code)	
≥,	and sealth m 27		Nancy Coulter-Kil	ey (Wife)	1						lney, M				
ore	I of H		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	0	Place of Dispo cemetery, cren	natory or of	her place		Jan 3				or Town, State	
Baltimore,	rtant:		`4 □Donation 5 □ Other (Specify		St	. Peter				2004				Springs,	N.Y.
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mimortant: If Item 27 Is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Exercitive mast be neithed at once.		21. Signature of Funeral Service Licen	hel		22	. Name and	Addres	s of Facility	y DeV	ol Fune	ra1	Home		
			23a. Part 1. Enter the disease, or comp	lications that caused	d the deat								sburg,	Md. 20	te
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each li	ne.		_				. ,			Interval Be Onset and	tween
	Pnysician /Medical		disease or condition resulting in death)	a. // Cul Due to (or as	a consen	VC/May	1 In	juty	ficie	ney				30 mi	untes
	Examiner			Hune	1. tre:	a tich				- 0				5 common	ž.
	n =	ner	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury	Duald (bras	a consec	uanoa of):								year	
	ecuter ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a. Hayes	. Li	pides	n a							5 year	15
8760,	cate be executed physician and the burial-transit	Ē	resulting in death) cast	Due to 🍼 as	a conseq	nce of):								/	
87	physicate I	dical		d.							-			1111111111	
× 6	that the death certific ied by the attending p detached for use as	Physician/Me	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy							23d. Date of d	eliven	
Вох	death atter	ciar	in the past 12 months?	1 □ Live birth 4 □ Pregnant a	2 Feta	Ideath 3⊡	Ectopic pre					1	Month		Year
P.O.	t the c by the achec	hys	9 Unknown	9□ Unknown											
S,	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as I	by P	Part II. Other significant conditions co	0 6	,			10			23e. Did to	bacco u	se contribute	to the cause of	death?
Ĕ	w requires t been signe should be	ted	Mistory of	Cevebr	o U	asou	lar	Acc	ide	ut	1 🗆 Y	es 2[	□No 3□F	Probably 4	Unknown
ပ္ပ	law r as be 2 sh	pie									24a. Was autop		24b. Were a	autopsy findings completion of c	available ause of
<u> </u>	: The cate h	Completed									perfor 1 ☐ Yes	med? 2 2 No	death? 1 ☐ Ye		
<u>≅</u>	icien Sertifi Sector	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o				
Division of Vital Records,	Attending Physicien: r death. ector: After this certifica by the funeral director,	2	1 Yes 2 No	1   Inpatie		ER/Outpatient 28b. Time of		Other	- 1101		ne 5 🗌 Resid 8d. Describe h			ecify)	
0	ding th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	Work'	?` es 2 □ N		ou. 200000 11	ow injury	00001100		
<u> S </u>	l or Attending after death. Director: After in by the funer	ifica	3 Suicide 6 Could not be 4 Homicide	28e. Place of Inj	ury - At ho	ome, farm, stre	eet, factory,	office		2				Rural Route Nurr	ber,
	tel or rs afte el Dir	Certification:	4   Horricide	building, et	c. (Sp <b>e</b> cir	y)				- 6	City or Tow	n, State,			
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) Certifying Phy	rsicien: To the best iner: On the basis o and manner st	f examina	wledge, death tion and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, deat	d place, a h occurre	nd due to the d d at the time, d	ause(s) date and	and manner a place, and du	as stated. se to the cause(s	s)
	To the within 2 To the complex	Ž	29b. Signature and title of certifier	5 0				License			1			oth, Day, Year)	•
1	5		Devet Mo	my m	ノ		1	47	682		3	Jænu	eary 21	6,2004	
			30. Name and address of person who c						_						
			Dr. Bennett T. Mc	orrison M. 32. Registr			ıney	sand	y Spr	ing	Rd. Olr	iey l	Md. 208	332	
	Sta Registr		JAN 2 9 20		ai s Sigila	5	Spo	ness	/						

		1	For State			land / Dep		nt of H	ealth a	and M	lental Hyg	giene	211	04	04172
			Registrar  1. Decedent's Name (First, Middle, Las	et)			7077041	-			2. Date of Dea			-	3. Time of Death
Physic	ciar										Month	Day	5 20	Yeer	9:40 PM
/Med				worthy				The late	1 1	- ( D 1)	Januar	$\overline{}$	5, 20 County		
Exam	inei	ľ	4a. Fecility Name (If not institution, give		nber)				Location of	or Death					
			4412 Chalfont Pla				1	theso	Ia If Under	24 Ure	0.0		ntgo		
Funera Directo	-		5. Social Security Number 6. S 220–26–1269	9X □M 2 <b>X</b> 1F	7. Age (In	yrs. last birthday	Months		Hours	Min.	8. Date of Birtl (Month, Day Aug. 14	y, Year) 19	26	9. Birth Cou	plece (State or Foreign ntry) New York
<b>p</b>		-	Usuel Residence of Decedent		100	c. City, Town or L	tio								10d. Inside City Limits
aryla shov			10a. State 10b. County		100	-									1X Yes 2 □ No
e Me	1	3	Maryland   Montgome	ery		Betheso									
ith th	Directo		10e. Street and Number				10f. Zi	p Code				10g. Cit	izen of V		intry?
23a	6	5	4412 Chalfont Pla	ce					316				USA		
dea dea	Cimoral	5	11. Marital Status	12. Was Dece Armed Fo		in U.S. 13.	Was Dece	dent of H	ispanic Ori in, Mexicar	igin? (Sp.	ecify Yes or No- Ricen, etc.)	.		e - Ameri k, White	can Indian, , etc.
afte afte	ű	2	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 📉 No e		1 🗆 Yes		Specify:				Specify	; <del>,</del>	71. * 4
ours in	7		3 ☐ Widowed 4X Divorced	Year or D	ates:									,	White
72 h	100		15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deci (Giv	edent's Usu e kind of wo DO NOT u	al Occupa ork done o	ation during mos	it of work	ing	16b. K	ind of Bu	siness/lr	ndustry
L Light L	potologo	-	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.		<i>ise retired</i> e Mal					wn I	Jama	
ed w	3	5 -					пош	e mai			- (Fires Adiabella				
al Head	á	מ	17. Father's Name (First, Middle, Last)								e (First, Middle,		Sumam	Θ)	
Men Men Men Men Men Men Men Men Men Men	F	2	Ferdinand Jelke,						-		Talmage	_			
Idn y Idnition 2.12.13-13-13-13-13-13-13-13-13-13-13-13-13-1			19a. Informant's Name/Relationship (				-				al Route Numbe	-			p Code)
C, IVC			Charlene Kenworth	y/ Daug							thesda,				Court Change
		Ì	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from		Ob. Place of Disp cemetery, cre				Jan.	27,				own, Stete
Deficiency Pages Department of Important: If its	,		* 4 ☐ Donation 5 ☐ Other (Specif		l I	Metropol				20			٠, ١	_	Lnia
permit. Departrimportri	once		21. Signature of Funeral Service Licer	(See)		4	22. Name a	nd Addres	ss of Faculi	Wis	Vol Function, D.C	eraı Ave.	HOT N	ne .W.	
0 8855	a		hur XX	1111					Wash	ingt	on, D.C	. 20	1007		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the ach line.	death. Do not en	nter the mo	de of dyin	g, such as	cardiac	or respiratory ar	rest.			Approximate Interval Between
Physicia	n		Immediete Cause (Final disease or condition	Metast	atic	Cancer									Onset and Death 3 Months
/Medica	al		resulting in death)	a. Due to	or as a co	nsequence of):									
Examine	r			h											
	<b>3</b>	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury that initiated events	Due to	or as a co	nsequence of):									
uted d ansit			Cause (Disease of injury that initiated events	c											
exec en an rial-tr		Š	resulting in death) Last	Due to	or as a co	insequence of):									
records, F.O. BOX 60100, e law requires that the death certificate be executed has been signed by the attending physicien and 92 should be detached for use as the burial-transit	1	2		_ d											
g phy	1	3													
o cent	1	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			□Ectopic p					1	23d. Dat	e of deliv	*
death death		2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregr	ant at time		Other (s						Moi	nth	Day Year
the ache	1	r II yaiciai v wedi	9 Unknown	9□ Unkn	own										
that shed the details	1	ý	Part II. Other significant conditions of	ontributing to d	ath but no	ot resulting in the	underlying	cause giv	en in Part I	l.	23e. Did to	obacco (	use conti	ribute to	the cause of death?
uld be		2	Pulmonary Fibro	osis							1 🗆 Y	/es 2	<b>⊘</b> No	3 🗆 Pro	bably 4 Dunknown
law requires as ueen sign		2									24a. Was	an			opsy findings available
The law ate has bage 2 st		Completed										rmed?		ieath?	ompletion of cause of
VICAL Ician: Ti certificate ector, pa		3	25. Was case referred to medical						OC Diag	a of Door	1 ☐ Yes h (Check only o	2X No	1	□ Yes	2 □ No
Of VILA Physician: rthis certific ral director,	C	0	examiner?	Hospital: 1 🗆	nnationt	2 ER/Outpatio	ent 3 🗆 D	Oth Oth	or		me 5 ⊡Resid		6 🗆 Oth	er (Spec	ifu)
Phys rthis	_ [F	- 1	27. Menner of Death	28a. Date (Mon				28c. Injur	y al		28d. Describe h				19)
ding Afte		2	1 XNatural 5 Pending investigatio		th, Day Ye	ear) Injury	м	Wor 1 □	k? Yes 2 ☐	No					
Vitten deal deal ctor:		2	3 Suicide 6 Could not b	e 28e. Place	of Injury	- At home, farm, s	treet, facto	ry, office						er or Rui	ral Route Number,
JIVISION I or Attending after death. Director: After	1	Certification.	4  Homicide determined	build	ng, etc. (S	Specify)					City or Tow	vn, State	9)		
spita ours seral			29a. Certifier 1⊠ Certifying Pt												
DIVISION OF VITAL INC.  To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		edical	(Check only 2 Medical Exer	niner: On the b		amination and/or									
othin ompl		Me.	29b. Signature and title of certifier		1	1	A 29	c. Licens	e number			29d. Da	te signed	d (Month	. Day, Year)
- s - o			* Klerin	(8.K)	la	lone	· <i>D</i> -	D231	27			Janı	ıary	26,	2004
12			30. Name and address of person who												
			Kevin Nealon, MI					vy C	hase.	MD	20815				
	State	e	31. Date filed (Month, Day, Year)	32. 5	egistrar's	Signature /	Sp								
Regi		- 1	JAN 28 20	04 4	char	~ /3	pop	uns							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Barbara Ann Kemenyas January 23, 2004 5:45 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Easton Talbot Talbot Hospice House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) Jan. 29, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 578-40-3464 71 1932 Washington, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, it a Medical Examirer must be nutified at 1 ☐ Yes 2 X No Directo Maryland Prince Georges Glenn Dale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5809 King Arthur Way 20769 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after de I Hygiene. other than "natural", or Itam 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If item 27 is marked other the
any injury or other traumatic Settlement Officer Title Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lawrence Stewart Mary Hayden ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Catlin / Daughter 9414 Highlander Blvd., Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-27-2004 Gate of Heaven Cem. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Pancreatic Cancer year Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of). Examiner death certificate be executed burial-transit and c Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy 1 Live birth ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached he 9 Unknown The law requires that the 9 Unknown s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 X Unknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No page , 1□ Yes or Attending Physician: ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Inpatient 2 ER/Outpatient ၉ 1 ☐ Yes 2X No Hospice 3□ DOA funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Injury 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00603335 January 26, 2004 Paul Bannen MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, MD 20832 Paul A. Bannen, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souke JAN 28 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** unu 2004 Bernice Gertrude Keane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2∏F Yrs. 1908 Washington, DC 95 March 5, Director 577-24-7695 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Middeal Examinational be notified at 1 X Yes 2 No Director Maryland Nottingham Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4403 Wynn Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) smit. Pages 1 and 2 should be filed within 72 epartment of Health and Mental Hygiene. portant: If Item 27 is marked other than "nu yorioury or other traumatic avent, the Musil nee. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk/Typist Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anton Botts Lillian Daile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Keane/ Son 4403 Wynn Road, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 30, Metropolitan Crematory

22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc.
500 University blvd. W., Silver Spring, MD 20901

Approximate Interval Between Interval Betwee 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5 CC 23a. Part1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardwascular Heart Discon Amerosurohi **Physician** Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, the attending physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Vo
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown ģ σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ eq 4 () nknown 1 Yes 2 No 3 Probably Record page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law certificate 1 ☐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Medical Certification: To 3 DOA 2 ETVOutpatient Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Vaturai 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January. address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21829 Ed and Mann 900 (2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 Registrar

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Year Frances 2004 05-30 Kavas 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hopcon 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) JUNE 25,1926 9. Birthplace (State or Foreign Country) NEW YORK 6. Sex 10 M X F Days Hours Min Months Yrs. 051-20-5432 77 Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 □ No MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14514 HOMECREST RD. #LL14 20906 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORRIS SCHOENBLUM REBECCA COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH HORWITZ/NIECE RED BARN DR., PALM COAST FL. 32164 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-26-2004 RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cartoryas Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuee of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: The Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

Examiner

Funeral Director

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be northed at once.

Baltimore, Maryland 21215-0020

/Medical

Physician/Medical Examiner ģ

physician end s the burief-transit The law requires that the death certificete be executed d for use es t signed by the et id be deteched fo has al or Attending Physician: T s efter death. if Director: After this certificat director, funeral ۵

Division of Vital Records, P.O. Box 68760,

Hospital 24 hours To the Hosp within 24 hou To the Fune completely fi Completed Be ဥ Certification: edicai

3

1 Yes 25 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of o	ertifier	
7	12/6	WD

29c. License number D0057884 29d. Date signed (Month, Day, Year) 24/224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Described and address of person who completed cause of death (Item 23a) 1801 E. JeffersRockille, MD 20852

State Registrar

31. Date filed (Month, Day, Year) JAN 28 2004 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician** Michael Lynn Kline, Sr. 1:30 a.m. 2004 23, /Medical January 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner North East Goosemar Road Extension Cecil If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Date of Birth (Month, Dey, Yeer) **Funeral** 1**X**MM 2□ F Hours Months Days Director 220-62-3737 45 May 10, 1958 Maryland Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylend Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel; or items 23s or 28s-1 show any injury or other traumatic event, the Medical Exerciper must be redified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Funeral Director Cecil Maryland North East 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 29 Goosemar Road Extension 21901 United States 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Detes 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Sheet Metal Contractors Sheet Metal Worker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Walter Kline Ethel Mae Ward 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 29 Goosemar Road Extension, North East, Maryland 21901 Laurel A. Kline/Spouse 20a. Method of Disposition 20b. Plece of Disposition (Neme of Date 20c. Location - City or Town, State North East Methodist January 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 28, 2004 North East, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 D 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Final disease or condition resulting in deeth) 0 Examiner Due to (or as e consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thknown ۾ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Be Completed 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No certificete 1 Tyes ours efter death.

erei Director: After this certificatilled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1€ No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of tnjury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours 29a. Certifier 1 critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner es steted. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated 29b. Signature, and title of certifier 29c. License number 29d. Dafe signed (Month, Day, Yeer) who completed cause of death (Item 23e) (Type, Print) 30. Neme end eddress of person Dul ·ec 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 2 9 2004 Registrar

DHMH 17 Rev 1/2001

Registrar

	Physicia /Medic		1 = State Registrar  1. Decedent's Name (First, Middle, Last) MARK EDWARD LEACH	State of Maryla		rtificate	of D	eath	ј 2 Ј.		Day 18 2	3. Time of Death Year 2004 2:00pm	
	Examin Funeral	er	4a. Facility Name (If not institution, give s CIVISTA MEDICA  5. Social Security Number 6. Sep	L CENTER	s. last birthday)	4b. City, To	PLAT Year			. Date of Birth (Month, Day,	CHAF	y of Death  RLES  9. Birthplace (State or Fore Country)	∍ign
	Director		069-40-6609         12           Usual Residence of Decedent         10b. County	M 2□F 56	Yrs. City, Town or Lo				N	OV 15,		NEW YORK	nits
	a-f sh	tor	MD CHARL	ES	NANJEM	OY						1 □ Yes 2 🛣	No
	or 28	Dire	10e. Street and Number 2250 SUGAR NUT PLA	A C E		10f. Zip C		2		10	g. Citizen of	What Country?	
036	4 within 72 hours after death with the Maryland jiene. Then "natural" or Itams 23a or 28a-f show the Maclical Examination notified at	l by Funeral Director		12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	i .		v		n? (Specr Puerto Ri	fy Yes or No- can, etc.)	Bla	USA ce - American Indian, ack, White, etc. fy: White	
21215-0036	thin 72 ho e. "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use	done dui	on ring most o	of working		16b. Kind of E	Business/Industry	
	200 C L	Co		4	Sof	tware	-			First, Middle, M	Comput		
and	b d la la	Be c	17. Father's Name (First, Middle, Last)	la						zalere	alderi Surria	me/	
Maryland	d 2 should be the and Menta the marked traumatic events.	2	Everett Gordon Lea  19a. Informant's Name/Relationship (Ty.		19b. Maili	ng Address (					City or Town	, State, Zip Code)	
	1 and 2 Health a Iem 27 Is		Sharon A. Bauman/V					P1ace		jemoy,			
altimore,	of of		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R	lamaval from State	. Place of Dispo cemetery, cre	matory or oth	er piace)		Dat			- City or Town, State	
	permit. Pages Department of Importent: If i any injury or one		* 4 □ Donation 5 □ Other (Specify)  21. Signature of uneral Service Ucens		ational	Par 2. Name and			25-20	004 F		hurch, VA	
Ba	Depa Impo any i		* Koru / //	lason				-		Church,			
1760,	Physician /Medical Examiner us pruist traisit	cal Exan iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a const	equence of):	10 N A R	4 &	E mB	0615	m		Onset and Death	
P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic preg						ate of delivery onth Day Year	
Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con If Y PERTENS 10  CORONARY A  CONGESTIVE	ntributing to death but not r	esulting in the u	inderlying cau	ise given	in Part I.			acco use con s 2 □ No	atribute to the cause of death?	
CO	aw rec is bee 2 shou	Completed	CORONARY A	RYERY DISE	FASE,	ANG	INA	PECT	ORIS	24a. Was ar		Were autopsy findings availa prior to completion of cause of	ble
- B	The lav	Com	CANGESTIVE	HEART F.	AILURI	E				perform		death? 1 ☐ Yes 2 ☐ No	
of Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				2	26. Place o	f Death (	Check only one			
on of	ding Phys h. After this funeral dir	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)			c. Injury a Work?	7 🗀 14878	28	5 Reside			
Division	To the Hospitel or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28ø. Place of Injury - At building, etc. (Spe				2 2 140		Location (Str City or Town		ber or Rural Route Number,	
	To the Hospitel within 24 hours To the Funeral completely filled	edical (	29a. Certifier (Check only one) 12 Cartifying Physical Examination (Check only one)	sician: To the best of my k nar: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at vestigation, in	the time,	, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) and m te and place,	anner as stated. and due to the cause(s)	
	To the within To the comple	M	29b. Signature and title of certifier	2 Comentel	1 ms.		License n			4	_	ed (Month, Day, Year) Py 18, 2004	
	(15)		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type,	Print)	-381 FICE		4 D L7				
15	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Sig			1 1 01	_ 1(O)	<u>עב                                    </u>	VPACKI	עניו :	20002	_

	1 - For State Registrar	State of Mary		artment of F		R	eg. No. 2004	
Physician	Decedent's Name (First, Middle, La.  Jack I	st) Landon				2. Date of Dear	bay, 2004	3. Time of Death 12:03 A M
/Medical Examiner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	Janaar	4c. County of Death	12.03 A
Examiner	Suburban Hospita			Bethes	da		Montgom	
Funeral Director	5. Social Security Number 6. S 232-46-4255	ex 7. Age (lr X M 2 ☐ F 7	n <i>yrs. last birthday)</i> 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 1	8, 1932 West	place (State or Foreign of Virginia
70	Usual Residence of Decedent							
and 21215-0036  be filed within 72 hours after death with the Maryland and Hygiene.  all Hygiene.  event, the Medical Exercit or them 23a or 28a-f show event, the Medical Exercit or must be rectified at the Completed by Funeral Director.	10a. State 10b. County Maryland Montgo		c. City, Town or Lo Betl	nesda				10d. Inside City Limits 1 ☐ Yes 2 No
Strength with the Marklers death with the Marklers 23a or 28a-1 out or most be rectified.	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?
th with	6001 Overlea Roa	ad		2081	6		U.S.A.	
tems	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
036 urs after alt, or I	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 MYes 2 □ No. If Yes, Give K Year or Dates:	orean	1□Yes 2XINo	Specify:		Specify: Wh	ite
5-00 72 hor matura	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	ing	16b. Kind of Business/In	dustry
21215-00 ed within 72 hou yegiene. Her than "natura is, the Medical Et, the Medical Et, the Medical Et.	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired tion Agen			American A	irlines
N 8 8 8 1 0	17. Father's Name (First, Middle, Last)	2			18. Mother's Nam			
Viante be wild be wild be whenta marked artic ev	William Leo La	andon				Colvil:		
Maryland 21215-0036 ad 2 should be filed within 72 hours aft tilth and Markal Hygilens 77 is marked other than "natural; or 17 traumatic event, the Medical Exact To Be Completed by F	19a. Informant's Name/Relationship ( Jean Fri / Sister	**			Rd., Beth		, City or Town, State, Zi <sub>l</sub> D 20816	Code)
Health tem 2:	20a. Method of Disposition		20b. Place of Dispo	sition (Name of			20c. Location - City or To	own, State
mol	1 ☐ Burial 2 【X Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Mt. Comf	matory or other plac ort Crema	tory 1/29	9/2004	Alexandria	, Virginia
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental hy Important: If item 27 is marked oth eny injury and then traumatic event once.  To Be (	21. Signature of Funeral Service Licer		MO1296	2. Name and Addre	ss of Facility Jos consin Ave	seph Gaw	ler's Sons, Washington,	Inc. DC 20016
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	a Chronic C	bstructi	ve Pulmor	nary Disea	ase		Onset and Death
/Medical Examiner		Due to (or as a co	onsequence of):					
je je	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (ur as a co	onsequence of).		•			
7760, te be executed systian and be burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	c						
	resulting in coatily cast	Due to (or as a co	onsequence of):					
4 7 9 0		_ d						
OX h cerr use use	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy	,		23d. Date of deliver	ery Day Year
. 0 00 0	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)			Month	Day 16ai
	Part II. Other significant conditions of	contributing to death but no	ot resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
cords, P w requires that been signed b should be dete						1 <b>X</b> Y€	es 2 □ No 3 □ Prot	oably 4 Unknown
Il Record The law require Tate has been sipage 2 should to						24a. Was a	y prior to co	psy findings available mpletion of cause of
	<u> </u>					perform 1 Yes 2		2 □ No
/ita	25. Was case referred to medical examiner?	Hospital:	•□=0/0 · · · ·	Oth	26. Place of Deat		e) ence 6 ⊡Other <i>(Specil</i>	<del>-</del>
	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier		y at		w injury occurred	у)
Vision (Vision of Attending In a death.	1 \( \bar{\text{N}} \) Natural 5 \( \bar{\text{Pending}} \) Pending 2 \( \bar{\text{Accident}} \) Accident	n	ear) Injury		Yes 2 □ No			
Division of or Attending Patter death.  Jin by the funers ertification:	3 Suicide 6 Could not b		- At home, farm, str Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rura n, State)	al Route Number,
Div  Div  To the Hospital or A within 24 hours after within 24 hours after completely filled in by  Medical Certif	(Check only 2 Medical Exar	nysician: To the best of miner: On the basis of exa	amination and/or in					
o the trithin 2 orther	29b. Signature and title of certifier	and manner stated		29c. Licens	e number	2	9d. Date signed (Month,	Day, Year)
3	> Zn	son/32	io, in	D DC	00571	24	1/281	104
3	30. Name and address of person who						20007	
	Truong Bao, M.  31. Date filed (Month, Day, Year)			Park Teri	race, Geri	mantown,	MD 20874	
State Registrar	JAN 28 20	32. Registrar's	w &	Sparks				

			1 - For State Registrar		State of	Maryla		artmen <i>rtificat</i>			and M	lental Hyg	giene 2 (	004	0418	30
I	Physic		1. Decedent's Name (First Dwight W. L.	a secondary								2. Date of Dea Month 1-25-0	Day	Yeer	3. Time of Dea 7:30 P.	
	/Medi Examir		4a. Facility Name (If not i		treet and num	iber)		4b. City,	Town, or	Location o	f Death	1-25-0		ty of Death	7:30 P.	
L			10700 Woods	dale Dr				Silv	er S	pring	3		Montg	omery	•	
	Funeral Director		5. Social Security Number 102-18-5227 Usuel Residence of Dece	1 🛭	IM 2□F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day 7-8-26			place (State or For htry) Y	eign
	rland ow			. County		10c. C	ity, Town or Lo	cation						1	IOd. Inside City Lir	nits
	a-f sh	tor	MD Mo	ntgomer	У	Si	lver Sp	ring							1 Tes 21	No
	or 28	Jirec	10e. Street and Number					101. Zip	Code			1	0g. Citizen of	What Cour	ntry?	
	ath w	rai	10700 Woods						209				U.S.	Α.		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ [	2 Married	12. Was Dece Armed For 1 ∑Yes If Yes, Give Year or Da	ces?		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, fy: Bla	etc.	
r C	72 ho	Completed		Decedent's Educ			16a. Dece	dent's Usua	al Occupa	tion	of working	20	16b. Kind of B	Business/Inc	dustry	
2	within ane. than	mpi	Elementary/Secondary		College (1-	4or 5+)		kind of wor								
, N	d be filed withi antal Hygiene. ced other than c svent, the M		17. Father's Name (First,	Middle, Last)	JT		Manage	er - (				liance (First, Middle, F	Dept.		abor	
a	d ta	To Be	George Law	vrence								Campbe]		116)		
ary	nd 2 should ith and Men 1th and Men 27 Is marke traumatic	-	19a. Informant's Name/R	Relationship (Typ	oe, Print)		19b. Mailir	ng Address	(Street a			Route Number		, State, Zip	Code)	
	1 and 2 Health a lem 27 Is		Allison Ro	binson	– Daugl		B232 W	loodst	ream	Ln.	E11:	icott Ci	ty, MD	2104	2	
saitimore,	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cre		emoval from S	tate	Place of Dispo cemetery, crer	sition (Nam natory or o	ne of ther place	)	D	ate	20c. Location	- City or To	wn, State	
	rimen rant:		`4 □ Donation 5 □ 0	Other (Specify)		Ga	te of E			1	L <b>-</b> 31-	-04	Silver	Spri	.ng, MD	
g	permit. Pages I Department of H Important: If ite any injury or ot once		21. Signature of Funeral	,	reput	.1.1	100	. Name an			11 111	es-Rina				
P	- S F		23a. Part 1. Enter the disc	sease, or complic	ations that ca	used the dea	th. Do not ent	<u>ilver</u> er the mode	Spr e of dying	ing,	MD 1 ardiac or	1800 Ne	w Hamp:	shire	2090 Approximate	4
	Physician /Medical Examiner		shock, or heart failu Immediate Cause (Final disease or condition resulting in death)		Cor		artery	disea	ase						Interval Between Onset and Death	
黄	*,	ner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Causa (Disease or injury	ns, b.	Due to (o	r as a conse	quence of):									
8/00,	centificate be executed iding physician and use as the burial-transit	dical Examiner	causs (Disease of injury that initiated events resulting in death) Last	c.	Due to (o	r às a conse	quence of):									
O. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1  Yes 2 No 9 Unknown	ITATIL		th 2 ☐ Feta ntattime of o	al death 3 🗀	Ectopic pre						te of deliver	ry Day Year	
corus, r	quires that n signed b	ρ	Part II. Other significent of Diabetes	conditions cont Mellitu	ributing to dea S	th but not re	sulting in the ur	nderlying ca	iuse giver	n in Part I.					e cause of death?	
ב ב	The lav ate has page 2	Completed	Hypertens	sion								24a. Was ar autopsy perform 1 Yes 2	red?	prior to com death?	osy findings availa npletion of cause of	ble of
V II d	ician: Sertific ector,	Be	25. Was case referred to examiner?		anital:						of Death	(Check only one	)			
5	Physic this cral dir	<u>۲</u>	1 ☐ Yes 2 🖾 No 27. Manner of Death	ПС	spital: 1 Inp		ER/Outpatient			4 U Nurs		e 5 Resider			)	
5	ding th. : After	tion		Pending investigation	28a. Date of (Month,	Day Year)	Injury	M	Sc. injury a Work? 1 □ Ye	at es 2 □ N	- 1	8d. Describe hor	w injury occuri	red		
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	Certification:		Could not be determined	28e. Place o building	f Injury - At h g, etc. (Speci	ome, farm, stre fy)			2 2 3 14		Bf. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,	
	To the Hospital or Al within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifier 1⊠ C (Check only 2 ☐ M one)	Certifying Physi Medicel Examin	cian: To the b er: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred a estigation,	it the time	, date and nion, death	place, ar	nd due to the cal d at the time, da	use(s) and ma te and place,	inner as sta and due to	ated. the cause(s)	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of	f certifier	, /				License			29	d. Date signed	d (Month, D	Day, Year)	
	8		· W	MADO	wf			D	19	400	1		emer	26	2004	
			30. Name and address of Charles Fra						Ave.	Silve	er Sr		V	•		
	Sta Registra		31. Date filed (Month, Day			gistrar's Signa		1	Kal			<u> </u>				

		1 - For State Registrar	State of N	Maryland	/ Depa	artment <i>tificate</i>	of H	ealth a Death	and Me	ental Hy	giene		04	81
	ician dical	Decedent's Name (First, Middle, TRUNG THI L			-					2. Date of De Januar	ath	2ď04	3. Time of 1	
3	niner	4a. Facility Name (If not institution, Shady Grove Adv		*		-	Town, or kvil	Location o			4c. Co	ounty of Deeth	у	
Funer Directo		5. Social Security Number 217–57–3358  Usual Residence of Decedent	.Sex 7. A 1 □ M 2 【X】F	Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da (ar. 1)	th 17, Year) 7, 193	9. Birthi Cour Vie	place (State or ntry) tnam	Foreign
Maryland	to	10a. State 10b. County	omery	10c. City, T Germ	own or Lo							1	0d. Inside City	
th with the 23a or 28s	Funeral Director	10e. Street and Number 11525 Dragonfir	e Way			10f. Zip		20876	5		10g. Citizer Vietn	n of What Cour	ntry?	
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Extrative French be recitized at	by Funer	3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 1 Yes 2 P	? No		Vas Decede Yes, speci		spanic Origin, Mexican Specify:		rfy Yes or No ican, etc.)		Race - Americ Black, White, becify: Asi	etc.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. Ite Medical Exterior read by recitived at	Completed	15. Decedent's (Specify only highest to Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4or	. 5 . \	6a. Deced (Give life. E Homen	ent's Usual kind of work OO NOT use naker	Occupat k done di e retired)	tion uring most	t of working	7		of Business/In	dustry	
yland  build be file Mental Hy arked other attic event.	To Be C	17. Father's Name (First, Middle, La Ton V. Le						Ngo	T. Da			,		1
e, Mar land 2 sho leath and m 27 is m		19a. Informant's Name/Relationship Thao Van Nguyen	_		11525	Drag	gonfi	ire W	lay Ge	rmanto	own, M	own, State, Zip Id. 2087	76	
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If Item any injury or other	b	20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Content of the Content	city)	e ceme	of H	ation (Name atory or oth	nerplace, 1 Cen	1. 2	an. 3	31,	Silve	ion-City or To er Spri		
Demii Depar Impor	SUC	21. Signature of Funeral Service Lic	Dey		10	East	Dee	er Pa	rk Dr		hersb	Home urg, Mo	1. 2087	7
Pnysicia /Medica		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a.	My o	car	dia	or aying,			ctio			Approximate Interval Between Onset and De 2	een aath
8760, sate be executed Examples and solution and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequence  s a consequence  s a consequence	4/7 se of). 7	_ A.	rtei			il asc			yeurs	
BOX 6 death certific e attending p	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown		e of pregnancy 2  Fetal dea at time of death	ath 3 □ E	Ectopic pred Other (spec					23d.	Date of delive Month	ry Day Ye	ar
cords, P.O w requires that the been signed by th should be detache	ed by P	Part II. Other significant conditions	contributing to death I	but not resulting	g in the und	derlying cau	use given	in Part I.			bacco use d es 2□N	contribute to the	e cause of dea	
I HeC The law ate has b page 2 sl	Completed									24a. Was a autop: perfor 1 Yes	sy	death?	esy findings av	allable ise of
on or ding Phys h. After this funeral di	ertification; To Be	25. Was case referred to medical examiner?  1	Hospital: 1 pati 28a. Date of Inju (Month, Da	ury 28b	Outpatient  D. Time of Injury	3□ DOA 280 M	Other: c. Injury a Work?	4 🗆 Nur	sing Home	Check only or 5  Reside  Describe he	ence 6 🗆	Other (Specify,	)	
DIVISION C tal or Attending P is after death. al Director: After ed in by the funers	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of In	jury · At home, tc. (Specify)	farm, stree	et, factory,	office		28f	Location (Si City or Town	treet and Nu n, State)	umber or Rural	Route Numbe	ir,
To the Hospital or Attention 24 hours after deal To the Funeral Director: completely filled in by the	edical	one)	hysicien: To the best iminer. On the basis of and manner st	or examination a	ge, death i and/or inve	stigation, in	my opin	lion, death	occurred	at the time, d	late and plac	ce, and due to	the cause(s)	
5 5 6	Σ	29b. Signature and title of certifler	1		- m	29c. l	License r	PP2	2	2	29d. Date sig	ary 2	ay, Year) 7, 200	,4
		30. Name and address of person who  Matthew o  31. Date filed (Month Day Year)	Henroth.	MO	-	rint)	Mes	licel	Cen	ter	Drive,	ary 2 Rock	wilk	M
S Regis	itate strar	31. Date filed (Month, Day, Year)  JAN 29 2	004 32. Hegisti	rar's Signature	G	Spa	Ks	/			/		,	

	Registrar Unpend ITem		r ME,G829	,3/12/04	wicate (	or Death		eg. No.	2004	C
an	Decedent's Name (First, Middle)						2. Date of Dea Month	th Day	Year	3. Time of Death
al	John Robert Lei						Januar	y 21	2004	8:45 PM
er	4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Tow	m, or Location of Deat	h	4c. C	ounty of Deeth	
	4411 Romlon S					ville		Pri	nce Geo	rae's
		6.Sex 1X M 2 ☐ F	7. Age (In yrs.		If Under 1 Y Months Da	ear If Under 24 Hrs ays Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign
	218-81-6587		42	Yrs.			Feb 6,			hington, DO
	Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Loc	ation					and beide on it is
'n	,			, 10 WI OI LOC	acion					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Director	Maryland Princ	ce George	es	Belts	ville_					
吉	10e. Street and Number				10f. Zip Cod	de	1	0g. Citize	n of What Cou	ntry?
a	4411 Romlon St.				2	20705		USA		
Funerai	11. Marital Status	Armed F			as Decedent Yes, specify (	of Hispanic Origin? (S Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14	. Race - Ameri Black, White,	
by F	1 Never Married 2 Marrie	If Yes, G	2₽ No live	1	Yes Z	No Specify:		S	pecify:	
0	3 Widowed 4 Divorced	Year or i	Dates:							ite
Completed	15. Decedent' (Specify only highest	s Education ! <i>grade completed</i>	)	(Give k	ent's Usual Oci and of work do	one during most of wor	rking	16b. Kind	of Business/In	dustry
m p	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. D	O NOT use re	itired)				
	12			Carper	iter					niversity
De	17. Father's Name (First, Middle, L	ast)				18. Mother's Nar	ne (First, Middle, M	Maiden Su	umame)	
0	Otis W. Lenox						E. Leno			
	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (Str	eet and Number or Ru	ral Route Number,	City or T	own, State, Zip	Code)
	Theresa E. Lenc	x/Mother		1403	Quebe	c St, Adel	phi, MD	20783	3	
	20a. Method of Disposition  1 Burial 2 Cremation	2 DB	20b. F	Place of Dispos	tion (Name o	place)	Date	20c. Loca	tion - City or To	own, State
	4 Donation 5 Other (Sp.		State	-	•	ematory Ja	n 25 200	74 T	0 - 1	MD
Ī	21. Signature of Fu, eral Service L	icensee		22.	Name and Ad	Idress of Facility Hin	os Pinol.	04 I	baltimo	re, MD
	1/2/11/1	. /	1. 111	11	800 No	TIII) TI Uomnahim	es-kinai	01 Ft	inerai	ноте g, MD 20904
	23a. Part. Enter the disease, or o	complications that	caused the deat	h Do not enter	the mode of	w manipsmin	e Ave, 5.	TIVE	r Sprin	Approximate
al Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence							
rnysician/medical	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		ctopic pregna			230	f. Date of delive	ury
	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of de		Other (specify				Month	Day Year
y	Part II. Other significant condition	s contributing to d	leath but not resu	ulting in the und	erlying cause	given in Part I.	23e. Did tob	acco use	contribute to th	e cause of death?
							1 🗀 Yes	s 2 🗆 N	lo 3 ☐ Prob	ably 4 Unknown
							24a. Was an		Idh Mora autai	any findings available
nanaldilloo							autopsy	,	prior to con death?	osy findings available inpletion of cause of
								□No	1) Yes	2□ No
	25. Was case referred to medical examiner?	Hospital:					th (Check only one	)		
2	XXYes 2 No	1 🗆		ER/Outpatient	3 DOX	-	ome 5 🗆 Resider		ther (Specify	)
	27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	V	ljury at Vork?	28d. Describe how	w injury o	ccurred	
	2 ☐ Accident investiga				M 1	☐Yes 2☐No				
	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 288. Place	of Injury - At ho	me, farm, stree	t, factory, offic	ce l	28f. Location (Stre		umber or Rural	Route Number,
		25,10	J (Speed)				City of TOWN,	J.(210)		
		Physician: To the	asis of examinat	wledge, death o tion and/or inve	ccurred at the stigation, in m	time, date and place, y opinion, death occur	and due to the cau red at the time, dat	use(s) and te and pla	d manner as sta ice, and due to	ated. the cause(s)
	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medical Ex	and man	ner stated.							
lealcal	(Check only 2 X Medical E)	and man	ner stated.		29c. Lice	ense number	29	d. Date si	igneo (Month, L	Day, Year)
ledical	one)	and man	ner stated.							, ,
Medical Certification:	29b. Signature and title of certifier	U. Kin	un,	239) /Time 15	0.0	ense number			igneo (Month, E	, ,
ledical	29b. Signature and title of certifier  30. Name and address of person with	de la complete de caus	un,		O.(	C.M.E.	J	anua	ry 22,	2004
Medical	29b. Signature and title of certifier	Me King	un,		O.(		J	anua	ry 22,	2004

Division of Vital Records, P.O. Box 68760,

			1- For Registrar Amend Itemsper	State of Maryla FHG828 2/18/04 I		artmen rtificate			and M		iene g. No.2	104	04	83
	Physici	an	Decedent's Name (First, Middle, Last)  T. D.C. Ell.  T. D.C. Ell.  T. D.C. Ell.  T. D.C. Ell.  T. D.C. Ell.  T. D.C. Ell.							2. Date of Dear Month		2004	3. Time of	
	/Medi	2000	LEST]		. స	4h City	Town or	Location o	of Death	Jan		y of Death	3:00	Рм
	Examir	ıer	Shady Grove Ac		so.	-		ille	J Douth			tgom	erv	
	Funeral Director		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Dey Mar 16		9 Right	lace (Stete o	r Foreign Col.
	land wo		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation						1	0d. Inside Cit	ty Limits
	Mary a-f sh	tor	Md Montgor	mery G	Saithe	rsbu:	rg						¹ <del>√</del> Yes	2 🗆 No
	th the or 28s	Jirec	10e. Street and Number			10f. Zip	Code	<del></del> -		1	0g. Citizen of	What Coun	try?	
	ath w	rai	776 Westside				2087				U.S			
920	72 hours after death with the Maryland natural; or Itams 23a or 28s-f show lical Experiment be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: 43 -		Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:		ecify Yes or No- Rican, etc.)		ce - Americ ick, White, i		
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	lent's Usua kind of wor DO NOT us	al Occupa rk done d	tion luring most	of worki	ng	16b. Kind of 8	Business/Inc	lustry	
121	within ene. than	Jdmo	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not us uper					N.	I.H		
102	filled Hygi Sther	Be Cc	8th Grade 17. Father's Name (First, Middle, Last)		1	<u> </u>			r's Name	(First, Middle, N				
ylar		To B	Lester Lewis					Lo	ouis	e Jone	s			
Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important; If item 27 is marke sny injury ocother traumatic once.		19a. Informant's Name/Relationship (Type							I Route Number				
	tem 2		Marguerite Lewis 20a. Method of Disposition		/ / O Place of Dispo cemetery, cren					thersb	20c. Location			-
E O	Pages nent of I unt; If it		¹X☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	dillovar iloni State				+	1 /áh	/2004	Rocky	ille	MD	
Baltimore,	Departing mports any injusting and injusting		21. Signature of Far and Service License	e Lange	/ 22	. Name and	d Addres	s of Facility	Snc	wden F	unera	1 Hor	ne, P	
ï	<u>0</u> 0 = 0		23a. Part1. Enter the disease, or compli	AUGUL OF						n St R		lle,	4D208	
	Physician /Medical		shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	ie cause on each line. $Seveve$	e Si	2P+;	C 9	Sho	C/2	-	ist,		Interval Betwo	veen
	Examiner			Due to (or as a consection of the consection of	quence of):	10-	fo	ction	2	45/120	thing-			
2	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	0.0	.,,,	( (10)	<del></del>	D	Rhm	OM		
	ecuter and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Pue to for as a consec	Chre	65 d	Va	Dein	lar	Acci	dent			
8760,	ate be executed hysician and the burial-transit	Icai		Acuto	0	nod	7	fal	INY	<del>(</del>				
.O. Box 6	that the death certificate be executed the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of	al death 3	Ectopic pre Other (spe						ite of deliver		ear
Records, P.	S	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the un	iderlying ca	ause give	n in Part I.			acco use con			
900	e law require has been sig je 2 should b	ompieted								24a. Was ar		Were autop	sy findings a	vailable
_	The ate h page	Com								autopsy perform 1 Tes 2	ed?	death?	ipletion of ca 2□ No	use or
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	osnital:					of Death	(Check only one	)			
of	Phys this al dii	. To	1 Yes 2 Death	+	ER/Outpatien			4 LI NUI	-	ne 5 Reside			)	
ion	Attending r death. ector: After by the fune	ation	1 Datural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	Injury	м	Bc. Injury Work′ 1 □ Y	? os 2 □ N		.00. 20001100 110	i injury cocci			
Division	in Sir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	et, factory,	, office		2	8f. Location (Str. City or Town,		er or Rural	Route Numb	er,
	e Hospital 24 hours a e Funeral i letely filled	edical (	29a. Certifier Certifying Phys	ician: To the best of my known and the basis of examination and manner stated.	owledge, death ation and/or inv	occurred a estigation,	at the time in my opi	e, date and inion, death	place, a	and due to the ca ad at the time, da	use(s) and ma te and place,	anner as sta and due to	ited. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	001	. 1	29c.	License				d. Date signe	d (Month, D	lay, Year)	
•	n		6-49-11	KIND	My	parker the	I	5-	29-	18	Jan. 2	24, 2	004	
			30. Name and address of person who con Hiru Khianey,				ente	r Dr	.,	Rockvi	lle, N	4D 20	850	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 28 200	32. Registrar's Signa	ature 4	Soo	re Kr	/						

RALPH M.  4a. Fecility Name (If not institution, give FORT WASHINGTON H  5. Social Security Number 6. Se 577-66-0976 Usuel Residence of Decedent 10a. State 10b. County MARYLAND PRINCE G  10e. Street and Number 7903 INDIAN HE	LICHAA  street and number)  (OSPITAL  X	O Yrs.  OXON H	OXON  If Under 1  Months		s. 8. Date of Birth	Day 22, 4c. Cour PRIN		3. Time of Deat 2:22A
5. Social Security Number  577-66-0976  Usuel Residence of Decedent  10a. State  10b. County  MARYLAND  PRINCE G  10e. Street and Number  7903 INDIAN HE	7. Age (In yrs 6)	Yrs.	If Under 1 Months C	Year If Under 24 Hr	). (Month, Day	Year)		ORGES
577-66-0976  Usuel Residence of Decedent  10a. State  10b. County  MARYLAND  PRINCE  10e. Street and Number  7903 INDIAN HE	10c. C	Yrs.	Months [		). (Month, Day	, Year)	9. BIT	
10a. State 10b. County  MARYLAND PRINCE C  10e. Street and Number  7903 INDIAN HE			ocation			, 174.	Co	hplace (Stete or Foreuntry)  GYPT
7903 INDIAN HE								10d. Inside City Lin 1 XYes 2
1 Never Married 2 Married	AD HIGHWAY  12. Was Decedent Ever in Amed Forces?  1   Yes 2 No   Yes, Give	ļ	Was Deceder	20745 nt of Hispanic Origin? y Cuban, Mexican, Pue	UN	14. F	STATE Race - Ame Black, White	S OF AMER
3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	Year or Dates:	16a. Dece	dent's Usual (	Occupation done during most of w	orking			
Elementary/Secondary (0-12)	College (1-4or 5+)					DEM	ጥተ ሮሞነን	V
17. Father's Name (First, Middle, Last)  MAURY LICE		DENIA	L IECH	18. Mother's N				Y
		1				-		
20a. Method of Disposition  1 XBurial 2 Cremation 3 I	20b.	Place of Dispo cemetery, crer	osition (Name matory or othe	of er place)	Date	20c. Locatio	on - City or	Town, State
		<b>ช</b> ี	ANZANS 170 RO	Address of Eachity SKY GOLDBER OCKVILLE PI	G MEMORIA KE, ROCKV	I CHA	PEL MD 20	INC. 852
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPERTENS Due to (or as a conse  C. DIABETES	equence of):  ION  equence of).	CTION					IINKNOWN
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live birth 2 ☐ Fe	tal death 3				1		livery Day Yea
Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	underlying cau	use given in Part I.				
					autop perfor	med?	death?	utopsy findings ava completion of caus
1 1 165 2 <b>X</b> 140	1 🗀 inpatient 2	1		Other: 4 Nursing	Home 5 Resid	lence 6 🗆		cify)
1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) 28e. Place of Injury - At	Injury home, larm, st	М	1 ☐ Yes 2 ☐ No	28f. Location (5	Street and Nu		ural Route Number,
29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurred at	t the time, date and pla in my opinion, death oc	ce, and due to the courred at the time,	cause(s) and date and place	manner as ce, and due	s stated. to the cause(s)
29b. Signature and trile of certifier	daning	>		License number				
	15. Decedent's Edu (Specify only highest grad	Specify only highest grade completed	15. Decedent's Education   16a. Dece   16b.   16a. Dece   16b.   2   2   2   2   2   2   2   2   2	15. Decedent's Education   (Specify only highest grade completed)   16a. Decedent's Usual (Give kind of word with the property only highest grade completed)   16a. Decedent's Usual (Give kind of word with the property only highest grade)   16a. Decedent's Usual (Give kind of word with the property only only highest grade)   16a. Decedent's Usual (Give kind of Word with the property only only only only only only only onl	15. Decedent's Education   15. Decedent's Education   15. Decedent's Usual Occupation   16. Decedent   17. Decedent   16. Decedent's Usual Occupation   16. Decedent   17. Decedent   16. Decedent   17. Decedent   16. Decedent   17. Dece	15. Decedent's Education   15. Decedent's Education   15. Decedent's Usual Occupation   15. December   15.	180. Nicholar (Speacht) Virging price occupied (Speacht) Virging price occupied (Speacht) Virging price occupied (Speacht) Virging virging occupied (Speacht) Virging virging occupied (Speacht) Virging virging occupied (Speacht) Virging virging occupied (Speacht) Virging virging occupied (Speacht) Virging virging occupied (Speacht) Virging virging	15. Deceler(*) Specify only righted grade completed)   16a. Deceler(*) Used Completed)   16b. Convolutions of Control of College (1-4or 5+)   2.

				epar <i>Certi</i>	tment ificate	of H	ealth a	and M		Reg. No	P 1 1 2 3	4 01	+ 185
	Physici /Media		1. Decedent's Name (First, Middle, Last)  Ilona Losonczy						2. Date of De Month January	Da	y Yea 2004	r	of Death
	Examir	er	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		Silve	er S	Location o	5	,		Montgo		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In yrs. last birth 83 Y  Usual Residence of Decedent		If Under Months	Days	If Under : Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Apr 18	h y, Ye <i>ar</i> ) , 192	9. B 20 Hui	irthplace (Stat Country) ngary	te or Foreign
	Maryland a-f show lied at	tor	10a. State 10b. County 10c. City, Town MD Montgomery Silver										City Limits
,	h with the 23a or 28 Ist be not	al Director	10e. Street and Number 10222 Meredith Avenue		10f. Zip (	Code 910					tizen of What (	Country?	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "neturet", or Items 23a or 28e-f show reumetic event, the Medical Extended must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:		s Decede 'es, speci		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - An Black, Wh Specify: W	nite, etc.	,
1215-0036	within 72 ho ane. Ihan "netur ne Medical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Deceder (Give kin life. DO		Occupa k done d e retired)	tion uring most	of worki	ing		ind of Busines		
Baltimore, Maryland 2121	m - V =	To Be Co	17. Father's Name (First, Middle, Last)  Istvan Varga	:mrs	<u> </u>				e (First, Middle, a Barta		Governi Sumame)	nent	
e, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury appeter treumetic a once.		Miklos F. Losonczy / Son 19	Mad	elin	e Pa	rkway	, Y	onkers,	NY	10705		
timor.	t. Pages riment of H		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  Gate of I	Heav	en C	emet	ery .	Jan 2		Sil		ring, M	m
Ra	permit. Departr Importe eny inji		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caused the death. Do no	500	O Uni	vers	sity B	lvd.	ncis J. W., Silv	er	ins Fur Spring,	MD 209	901
	death certificate be executed  Table attending physicien and muse as the burial-transit drouse as the burial-transit and the property of the p	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Acute Myocardial  Due to (or as a consequence of b. Arteriosclerotic Due to (or as a consequence of c. Due to (or as a consequence of d.	Inf f): Car	farct	ion				est,		Approxim Interval B Onset an immedi	d Death .ate
	death certifi e attending p id for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		topic pre						23d. Date of de Month	elivery Day	Year
rds, P	w requires that the been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in t	the unde	erlying cau	ıse giver	n in Part I.				se contribute t ⊠No 3 □ P		
Hec	The law ate has b page 2 st	Completed							24a. Was a autops perfor 1 Yes	SV	24b. Were a prior to death?	utopsy finding completion of s 2 \( \square\$ No	s available cause of
DIVISION OF VITAR	To the Hospital or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director,	ertification; To Be	2 Accident investigation	me of jury	286 M	Other C. Injury : Work? 1  Ye	: 4 □ Nurs	sing Hon 2	(Check only or ne 5  Reside 8d. Describe h	ence 6 ow injury	y occurred		
2	spital or A ours after nerel Direc filled in by	O	28e. Place of Injury - At home, farm building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, containing the second not be set of my knowledge, containing the second not be set of my knowledge, containing the second not be set of my knowledge, containing the second not be set of my knowledge, containing the second not be set of my knowledge, containing the second not be set of my knowledge, containing the second not be set of my knowledge.				data and		8f. Location (S. City or Town	n, State)	)		mber,
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/one)  29b. Signature and title of celetifier	or invest	29c.	n my opi	nion, death number	occurre	d at the time, d	ate and 9d. Date	place, and du	e to the cause th, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Ty		nt)	2153					23/2004	·	
	Sta Registra		G. Peter Pushkas M.D., 11510 Old G. 31. Date filed (Month, Day, Year)  JAN 28 2004  32. Registrar's Signature	eorg	-	n Ro		Kock	ville,	MD 2	20852		

Dhysia	20	1 - State Registrar MFND#290perMD  1. Decedent's Name (First, Middle, Las	t)		rtificate o		2. Date of D	Da	y Year	3. Time of Death	
Physici Medid		Rose McGuire	Lynn						2004	4:45 A.	
Examir	ner	4a. Facility Name (If not institution, give	street and number)		_	, or Location of Deat	h	40	. County of Deat		
		Rebecca House  5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)	Poto If Under 1 Ye		8. Date of B	linti9 = 3	Montgom - 19219. Birt	ery hplace (State or Fore untry)	
uneral irector			□M 2\\ F	82 Yrs.	Months Day		(Month, I	Day, Year)	921 1	New Jersey	
a-f ehow	ctor	Oa. State Virginia Maryland Montgom	ery.	10c. City, Town or Lo Arlingto		mac_				10d. Inside City Lim 1 ☐ Yes 2	
23a or 28	Funeral Director	10e. Street and Number 1221 South Ea - 9910 River Road	ds Street	:	10f. Zip Code 2220	)2 <del>20854-</del>		10g. Ci	tizen of What Co	untry?	
integral and marked other than "natural", or iteme 23s or 28s-f show other treumstic event, the Medical Examples must be multipled at	by Funer	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ N	of Hispanic Origin? (S uban, Mexican, Puerl No <i>Specity:</i>	pecify Yes or No Rican, etc.)	10-	14. Race - Ame Black, White Specify:		
An "nature Medical E	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	(Give	dent's Usual Oc kind of work doi DO NOT use ret	cupation ne during most of woi ired)	rking	16b. K	(ind of Business/		
4 #	Con	12			memaker				n Home		
is marked other than eumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last)  Robert McGuire				18. Mother's Nar Kathai	•	e, Maider iffor			
# m m	1	19a. Informant's Name/Relationship (7			-	et and Number or Ru				Tip Code)	
em 27 i	1	Katharine L. Tho	rnton -daug	h 383 F 20b. Place of Dispo		t., Newark	C, New .	-		Town Chata	
ここりし		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other p	nlace)			ocation - City or		
ortent: injury		'4 □Donation 5 □Other (Specify		Mt. Oliv			23, 2004		ld1etown		
Impoi any ir		21. Signature of Funeral Service Licen	111	/		dress of Facility Jo	- 9.0				
		22a Parti Inter to disease or com	all alions that caused			consin Ave			illigion,	DC 2001	
		23a. Part1. Inter 1 - disease, or comp shock or her it ailure. List only	e cause on each lin	θ.		.,g, 02011 20 0210121	,	277001,		Interval Between Onset and Death	
sician ledical		Immediate Caure (Final disease or coor ition resulting in drath)	u	ssive Deme	entia						
aminer			•	consequence of): erebral He	morrhao	۵					
Z"	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	t consequence of).	morrinag						
sicien and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events									
an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):							
ysicien ie burial	cal		d								
ng ph as th	Medi	15.55111.5						I			
ed by the attending physi detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1	2 Fetal death 3	Ectopic pregnal Other (specify)				23d. Date of deli Month	ivery Day Year	
signed b	by Pl	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
n sig	o pe						1 [	Yes 2	<b>X</b> No 3□Pro	obably 4 Unkno	
s been si	Completed						24a. Wa		24b. Were au	topsy findings availal	
page 2	E O						per 1 Yes	opsy formed? 2 <b>X</b> No	death?	2□ No	
certificate rector, pag	a)	25. Was case referred to medical				26. Place of Dea					
5 D	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🗌 Inpatier	nt 2 🗆 ER/Outpatier	nt 3□ DOA	Other: 4 Nursing H	lome 5∭ Res	sidence	6 Other (Spec	cify)	
To the Funeral Director: After the completely filled in by the funeral		27. Manner of Death 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	gation M 1 ☐ Yes 2 ☐ No								
el Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, offic	ce ·		(Street ar own, State		ral Route Number,	
To the Funerel Completely filled	edicai	29a. Certifier 1	ysician: To the best c liner: On the basis of and manner sta	examination and/or in	h occurred at the vestigation, in m	time, date and place y opinion, death occu	, and due to the	e cause(s) , date and	) and manner as d place, and due	stated. to the cause(s)	
To the	Σ	29b. Signature and title of certifier		4	29c. Lice	ense number		29d. Da	te signed (Month bruary	1, Day, Year)	
(0		> Elijanutu L	MANNY W	4/	Dc	13738		Jan	uary I,	2004	
9											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #5,02/06/04,T.M. KentCo-State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) LILES 07254 **Physician** JANUARY 2004 MCKAY ANNE /Medical 4b. City, Town, or Location of Death
CHESTERTOWN 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTER RIVER HOSPITAL CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Days 363149336 ILLINOIS JULY 2, 1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, it is Macified Exemiter must be notified at once. 1 Yes 2 □ No KENT CHESTERTON MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A POINT 21620 ERON 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Be Completed by 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education ify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4RTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BOWEN (UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (ype, Print) TRUMBAYER 331 PARK LANE, CHESTERTOWN, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST PAULS CEMETERY 23/04 FAIRLES, MID 4 ☐ Donation 5 ☐ Other (Specify) GREEN HEROW WAY CHESTERTUN 21. Signature of Funeral Service License FUNZEAR DIREC Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUNSI **Physician** /Medical **Examiner** Sequentially list conditions burial-transit and Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A complately filled in by the fu

ally, leading to inheritate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	nce of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	eath 3 ☐Ectopic				23d. Date of delin Month	very Day Year
Part II. Other significant conditions of	ontributing to death but not result	ing in the underlying	cause given in	Part I.	1 🗆 24a. Was		
					1 ☐ Yes	2 ☐ No ☐ 1 ☐ Yes	2 🗆 No
25. Was case referred to medical examiner?	Uitali		Othor		h (Check only		
1 Yes 2 No	Hospital: 1 ← Impatient 2 ☐ El	R/Outpatient 3 🗆	DOA CUIBI. 4	Nursing Ho	me 5 Res	idence 6 Other (Spec	rify)
	(Month, Day Year)	8b. Time of Injury M	28c. Injury at Work? 1  Yes	2 🗆 No	28d. Describe	how injury occurred	
27. Manner of Death  1	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, facto	ory, office		28f. Location ( City or To	(Street and Number or Ru own, State)	ral Route Number,
29a, Certifier 1 Certifying Ph	ysicien: To the best of my knowl niner: On the basis of examination and manner stated.	ledge, death occurre on and/or investigation	ed at the time, don, in my opinio	ate and place, n, death occur	and due to the red at the time,	cause(s) and manner as , date and place, and due	stated. to the cause(s)
29b. Signature and title of certifier		2	9c. License nu	mber		29d. Date signed (Month	, Day, Year)

n-cu138-24

ZICZO

1-22-04

DHMH 17 Rev 1/2001

State

Registra

CHEST EATOUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

31. Date filed (Month, Day, Year)

JAN 2

			For	ricase			d / Depa	artment of	Health	and Mer	ntal Hy	giene	2001	. 01	. 100
			State Registrar				Cei	rtificate of	Death		Date of De	Reg. No.	200.	3 Time	of Death
	Physici	an	1. Decedent's Name	e (First, Middle, Las	Burg	^	1	(1 43		40 August	Month A N	7 Day	200 4	18	220 M
	/Medic		4a. Facility Name (II	not institution, give	street and number	!\ nr)		4b. City Town,	or Location		DW/A	4c. (	County of Deal	h	
	Examili	er	Checter	0	lospital	Cen	ter	Ches-	ter-	Town			Kent	-	
	Funeral		5. Social Security N	umber 6. Se		Age (In yrs.	last birthday)	If Under 1 Yea Months Days			Date of Bir (Month, Da		Co	hplace (State untry)	e or Foreign
	Director		408-12-1	3942	- W 2 - X	88	Yrs.			00	ct. 8	, 191	5 Ter	nesse	e
	ow a		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside	
	Many a-f sh	tor	MD.	Kent			Rock I	lall						1 😿 Y€	es 2 No
	th the or 284	Director	10e. Street and Nur	nber			•	10f. Zip Code				10g. Citiz	en of What Co	untry?	
	ath wi	rai	5799 1	Whale Poi			0 140	216		Ninia 2 /Canais	. Voc. or Ni		SA 4. Race - Ame	ncan Indian	
	Rems	Funerai	11. Marital Status	ied 2□ Marnied	12. Was Deceder Armed Force 1 ☐ Yes 2 €	s?	.S. 13.	Was Decedent of If Yes, specify Cu	ban, Mexic	an, Puerto Ric	an, etc.)	,	Black, Whit		
980	urs af	ξ	3 Widowed		If Yes, Give 2 Year or Date:			1 □ Yes 21X No	Specify	y:			Specify: V	Mite	
ည်	within 72 hours after death with the Maryland ene. than "netural", or items 23s or 28s-f show fra Medical Exertine mast ke truffind at	Completed	(Spec	15. Decedent's Ed	ucation de completed)		(Give	dent's Usual Occi	e during mo	st of working		16b. Kin	d of Business	Industry	
2	han han	mple	Elementary/Seco	ndary (0-12)	College (1-40	or 5+)	life.	DO NOT use retir	ed)			Λ.	ccounti	n°C	
Q	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "netural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name			-		CPA	18. Mot	her's Name (F	irst, Middle			115	
an	should be nd Mental marked c	To Be	Hugh 1	Preston O	wen					Susan I	avis				
ary	should and Men is marke sumatic		19a. Informant's Na	ame/Relationship (7	ype, Print)			ng Address (Stree							
Σ	12 를 다			S. lang		20h E		Whale I	Point	Lane,			, Maryl cation - City or		1661
ore	80=5			Cremation 3		te C	emetery, cre	matory or other pl e Cemete		2/3/20			ville,		3998
Baltimore, Maryland 21215-0036	nit. Pages partment of ortent: If it injury or c			5 ☐ Other (Specify Ineral Service Licen		10			- 1			1			
Ba	permit. Departr Importa any inj		Bu	60/2	ellers		F	Name and Add Tellows, 130 Spec	Helfe er Roa	enbein ad Ches	& New	vnam l ovn. I	Funeral Md. 216	Home 20	, P.A.
			23a. Part1. Enter to shock, or hea	he disease, or comp rt failure. List only	olications that caus	sed the deat								Approxim Interval E	nate Between
	Physician	8	Immediate Cause disease or condition	(Final	· Pon		A 1150	Penin	c U	ccon				Onset an	Hems
	/Medical Examiner		resulting in death)	(	Due to (or	as a conseq	uence of):								
	Examine,	-	Sequentially list co if any, leading to in cause. Enter Under	nditions,	b	as a conseq	uence of):								
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury	ì										
oʻ	sician and burial-transit		resulting in death)		Due to (or	as a conseq	uence of):			-					
3760,	₩ > ₩	cai		•	d										
x 68	ertific ding p	Physician/Med	IF FEMALE:		23c. If yes, outcor	me of pream:	ancy					2	3d. Date of de	iven	
Вох	eath c attend for us	cian	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fete	death 3	☐Ectopic pregnar ☐ Other (specify)	cy				Month	Day	Year
0	the d by the ached	hysi	1 ☐ Yes 2 € 9 ☐ Unknown		9□ Unknowr	1									
s, D	The law requires that the death certifica tte has been signed by the attending ph page 2 should be delached for use as it	by P	Part II. Dther signif	ficent conditions c	ontributing to deat	h but not res	ulting in the u	inderlying cause (	given in Par	t I.			se contribute to		
Vital Records,	w requires t been signe should be										1 🗆	Yes 21	3 □ PI		
ec	elawr hasbe ge 2sh	Completed									24a. Was auto		24b. Were at prior to death?	itopsy finding completion o	s available cause of
al H			05.111	and the second second					00.01-	- a of Dooth //	1 ☐ Yes	2 40	1 ☐ Yes	2 No	
		To Be	25. Was case referexaminer?		Hospital: 1 Hippi	atient 2	ER/Outpatie	nt 3 DOA	th ar	ce of Death (C Nursing Home			☐Other (Spe	cify)	
ı of	g Physier this	n: T	27. Manner of Deal	th	28a. Date of I (Month,		28b. Time o		ury at ork?	280	d. Describe	how injury	occurred		
sior	Attending r death. ector: After by the fune	atic	1 Natural 2 Accident	5 Pending investigation 6 Could not be					□Yes 2[		1 Mar	/O:	/ A/	······································	
Division of	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	280. Place of	Injury - At h etc. (Special	ome, farm, st fy)	reet, factory, offic	θ	281		(Street and own, State)	d Number or R	Jrai Houle IV	umber,
_	To the Hospitel or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only	1 ☐ Certifying Ph	ysicien: To the be	est of my kno	owledge, dear	th occurred at the	time, date	and place, and	due to the	cause(s)	and manner as	s stated.	e(s)
	the H hin 24 the F nplete	Medical	one) 29b. Signature and		and manner	stated.			nse numbe				signed (Mont		
	To To		Signature and	1 of As	10000								9-200		
			30. Name and add	ress of person who	completed cause of	of death (Iter	m 23a) (Type		1382	- 7					
_			Dr. John	n C. Seym	our, M.D.	. 122	Speer	Road Che	ester	town, M	lary1a	and 2	1620		
	Sta Regist		31. Date filed (Mor	JAN 3 0	2004 32. Re	Strar's Signa	ature	book							

			1 - For State Registrar	State of Ma		ertificate		nd Mental Hy	giene 20	04 04189
П	Physic	ian	Decedent's Name (First, Middle, Last)	,				2. Date of De	ry 21, 20	3. Time of Death
1	/Medi	cal	HUGO  4a. Facility Name (If not institution, give:		Montiel					1038 A.
	Exami	1er	4002 Lottsford V:	,		4b. City, Tow	n, or Location of Lanham	Death	4c. County o	
	Funeral		5. Social Security Number 6. Sec	x 7 Age	e (In yrs. last birthday	) If Under 1 Y	ear If Under 2			9. Birthplace (State or Foreign Country)
1	Director		none 1	<b>3</b> M 2□ F	24 Yrs.	Months Da	ays Hours	Min. (Month, De March	8, 1979	Mexico
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryi f sho	ō	Maryland Prince G	eome's			anham			1 StYes 2 □ No
	r 28a	rec	10e. Street and Number	corge s		10f. Zip Cod			10g. Citizen of W	
	th witi	al D	6838 Riverdale	Road			20706		Mex	kico
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show Ite Medical Exeminer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13	Was Decedent If Yes, specify (	of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	)- 14. Race	- American Indian, , White, etc.
36	s afte	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 N If Yes, Give	lo	1 <b>∑</b> Yes 2□		Mexican	Specify:	White
21215-0036	2 hour	edt	15. Decedent's Edu	Year or Dates:	16a, Dec	edent's Usual Oc	cupation		16b. Kind of Bus	iness/Industry
215	hin 72 a. ma "na Medii	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e com <i>pleted)</i> College (1-4or 5	(Giv		ne durina most o	of working	TOD. KING OF BUS	messmoustry
21	filed within Hygiene. other than than ant, the Market han ant, the Market han ant, the Market han ant, the Market han ant and and ant and and and and and and and and and and	Com	8th		7	Constr	action W	orker		Private
pu	be file d oth	Be	17. Father's Name (First, Middle, Last)  Hugo V. Herna	ndoz				s Name (First, Middle,		)
Maryland	should that marked umatic e	10	19a. Informant's Name/Relationship (Typ		405 14 3			ilomena M.		
Z	C1 02 = 81		Angel U. Hernande		n) 10	ols Gree	eer and Number enbelt R	or Rural Route Number oad	er, City or Town, S Lanham M	tate, Zip Code)
re,	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of	!	Date		ity or Town, State
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 🕅 R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Panteon	matory or other. Municip		/30/2004	Actopan	Vera Cruz
alti	permit. Page Department Important: If any injury of once.		21. Signature of Funeral Service License	e /		2. Name and Ad	Idress of Facility	Rendon/Ha	le Funera	al Home
-	207 29		23a. Part 1. Enter the disease, or complications shock, or heart failure, List only on	Jens.				Road, Lan		0706
	Physician /Medical Examiner  The privative of the privati	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	2) g He	ed (1).	and Regs	t They's	Cr Onset and Death
P.O. Box 68760	the death certificate by the attending phy ached for use as the	Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown	I	Petal death 3	□Ectopic pregna □ Other (specify,	)		23d. Date Month	
	w requires that been signed I should be det	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in the c	inderlying cause	given in Part I.	23e. Did to		ute to the cause of death?
Vital Records	The taw ate has b page 2 si	e Completed	25. Was case referred to medical					-	rmed? prio 2□ No 1	ere autopsy findings available or to completion of cause of ath? Yes 2 \sumbed No
		0 8	examiner?	ospital:	t 2 ER/Outpatie	nt 3 DOA	Ther	f Death <i>(Check only o</i> ing Home 5 <del>☑</del> Resid		(Canada)
101	ng Phys ter this neral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o				ow injury occurred	
Sior	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	1/2/10X	100) 1 milary		☐Yes 2 No	Sulpe	+ shot	_
Division of	i Dire	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		eet, lactory, office	Ce T	281. Location (S City or Tow	ireet and Number in, State) 400	or Rural Route Fum er.
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examin	ier: On the basis of e	examination and/or in	h occurred at the vestigation, in m	time, date and p y opinion, death	place, and due to the o occurred at the time, o	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and manner state	BQ.	29c. Lice	ense number	2	29d. Date signed (i	Month, Dev. Year)
)			IThe 1.	1 Kin		0.0	C.M.E.		January :	
)	(3)		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Type,	Print) 111 T	Donn Gt			
			THEODORE MIKE				rein Str	eet, Balti	more, Ma	ryland 21201
300	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 2 6 2004	32. Registrar	's Signature	E .				

	-	For State Registrar	State of Maryland		rtment of H		Mental Hy	/giene Reg. No.	2004	04190
Dhuniai		1. Decedent's Name (First, Middle, Las	0 1/				2. Date of D Month	eath Day	Year	3. Time of Death
Physicia /Medic		George	Melton				Janu		16, 2004	8107 A.M
Examin	er	4a. Facility Name (If not institution, give	11 - 1/.1	104	4b. City, Town, or		atn		County of Deeth	
F		5. Social Security Number 6. Se	TACS HOSPITAL T. Age (In yrs. le	(enter	Chever1	If Under 24 H	Irs. 8. Date of B	irth	ince G	eorges place (State or Foreign ntry)
Funeral Director			M 2□F 51	Yrs.	Months Days	Hours M	in. (Month, D	29, 1	952 Ge	orgia
D D		Usual Residence of Decedent		-						
arylar ahow	2	10a. State 10b. County		, Town or Lo			-			10d. Inside City Limits  1y□ Yes 2 □ No
he M	ecto	MD Prince	Georges   Cap	itol	Heights			10a Citi	zen of What Cou	
with B or	Funeral Director	6611 Ronald Ro	ad			0783			USA	,
Jeath	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of His Yes, specify Cubar		(Specify Yes or N	lo-	14. Race - Ameri	
be filed within 72 hours after death with the Maryland tall tygiene. Ide tygiene. Ide other than "natural", or items 23a or 28a-f ahow event, the Medical Examiner rount be notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ MDivorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cubar ☐ Yes 2 12 No	Specify:	erto Hican, etc.)		Black, White, Specify:	etc. Black
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	lent's Usual Occupa	lion	working	16b. Kir	nd of Business/Ir	dustry
ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d OO NOT use retired)		Johnny	Go	vernmen	nt
oe filed with lat Hygiene d other tha		17. Father's Name (First, Middle, Last)	+4	Musi	c Teac		Name (First, Middl	a Maiden	Sumamal	
S is b s	Be	George Melto	n Jr.			Alwei		fton		
Z should by and Menta and Menta is marked aumatic evanuatic evanua	2	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street a					Code)
ite, Ind I yld s 1 and 2 should t Heelih and Mer liem 27 is marke other traumatic		Alwena Ashford		738	E 104+	h P1a	ca Chic	ago.	T11in	is 60628
es 1 a of Hee		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other place		Date		cation - City or T	
difficulting milt. Pages partment of portant: If it portant: If it y injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify		ERSID	E CEMET	ERY 1-	-27-04	ALB	ANY, GI	EORGIA
permit. Pages beartment of important: If I any injury or once.		21. Signature of Funeral Service Licen	see O	22	. Name and Addres	s of Facility	raylor'	S FU	NERAL I	HOME
20519		175.0.0	auxer						W WASH	DC 20001
Physician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	iac	Arrhyt	Limia Caro	nac or respiratory	arrest,		Approximate Interval Between Onset and Death
Examiner			He	perk	alemia	_				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):		0				
ate be executed thysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pui	mon	ary E	dema	Name .			
fou, e be exercisen a		resulting in death, cast	Due to (or as a consequ	ience or):	U					
physicate physicate	dicai	•	d							
GOFIGS, P.O. BOX 08/ w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deliv Month	ery Day Year
The law requires that the ate has been signed by the page 2 should be detached.	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	ılting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	he cause of death?
quires n sign							_ 1□	Yes 2	X <sub>No</sub> 3□ Pro	bably 4 Unknown
law requires law seen signer 2 should be	ompleted						24a. Wa	s an opsy	24b. Were auto	opsy findings available impletion of cause of
N VICAL MEC hysician: The law his certificate has b i director, page 2 sl	Com						per 1 Yes	formed?	death? 1 ☐ Yes	2 ( <b>X</b> No
VICAL ICIAN: 1 Certificat rector, pr	Be (	25. Was case referred to medical examiner?					Death (Check only			
	ပ္	1 ☐ Yes 2 🛣 No		ER/Outpatien			g Home 5 ☐ Res			(y)
Jing After fune	ertification:	27. Manner of Death  1/□Matural 5 □ Pending  2 □ Accident investigation  3 □ Suicide 6 □ Could not be	1	28b. Time of Injury	28c. Injury Work M 1 🔲	at (? ∕es 2 □ No	28d. Describe			
DIVISIO  pital or Attendi  ours after death.  lerel Director: A  filled in by the ft	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office			(Street and own, State		al Route Number,
UNISIG	edical		ysician: To the best of my knowniner: On the basis of examinat and manner stated.							
To t To t	Ž	29b. Signature and title of certifier	NSO.		29c. License	54846	F		e signed (Month,	Day, Year)
4		30. Name and address of person who	completed cause of death (Item	23а) (Туре.	Print)					
			A - 3001 HOS		DRIVE,	CHEVI	ERLY, M.	ARYL.	AND 20	785
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	<i></i>					
Regist		JAN & ( 2004	Bear &	Span						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Per No. 2 0 0

			For 1 - State Registrar Amend Item#24a	State of Maryland / DeperVERBALG8282/25/04@	partment of Health and N Wrtificate of Death	Mental Hygier	2001	04191
	Physici	an	Decedent's Name (First, Middle, Last)	- 4		2. Date of Death	Day Year	3. Time of Death
2	/Medic Examin	_	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death	. 000
Ĺ	LXaiiiii	G.		GRAL HOSPITAL	BERLIN If Under 1 Year   If Under 24 Hrs.	O Data of Birth	WORCE	
	Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last birthda	(y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yei		ace (State or Foreign  DE
10	ס		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or	Location			Od. Inside City Limits
15	Manyla f shov	ō	MD WORCES		BERLIN		, ,	1 Yes 2 □ No
1 7	r 28a-	Irect	10e. Street and Number	3167	10f. Zip Code	10g.	Citizen of What Coun	try?
	ath wit	raio	508-BAY ST.	ApT. 13	21811		USA	
36	be filed within 72 hours after death with the Maryland lat Hygiene. dother than "netural", or items 23a or 28a-1 show evant, the Medical Examere nutles notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  12 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 No Specify:</li> </ol>	pecify Yes or No- p Rican, etc.)	14. Race - America Black, White, e	
21215-0036	72 hou netura dical E	eted	15. Decedent's Educ (Specify only highest grade	nation 16a Dec	cedent's Usual Occupation ive kind of work done during most of work io. DO NOT use retired)	king 16b.	. Kind of Business/Inc	lustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	O. DO NOT use retired)  OICK DANER	1	MAUNTA	AIRE
	e filed Il Hygie other vant,	BeCc	17. Father's Name (First, Middle, Last)	^/		ne (First, Middle, Maio	len Sumame)	77150
Maryland	should be ind Mental marked c	T0 E	SOSEPH	MITCHELL	- LILLIAN	) HAND		HELL
Mar	s 1 and 2 should Health and Men itam 27 is merks other traumatic		19a. Informant's Name/Relationship (Ty)	) / 100	illing Address (Street and Number or Ru	ral Route Number, Cit BERLIN		Code)
6	es 1 an of Heal f itam 2 r other		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)		Location - City or To	wn, State
ino	O O		1 Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	emoval from State CALVAR	PENTECOSIAL 1		ISHOPVILLE	
Baltimore	permit. Page Department important: i any injury o		21. Signature of Funeral Service License	6	22. Name and Address of Facility		SMITH F	
	40244		23a. Part1. Errer the disease, complished, or heart failure. List only on	cations that caused the death. Do not e	enter the mode of dying, such as cardiac		BURY MI	Approximate Interval Between
100	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	Pulseless Ele	ectrical Activity	(Cardine)	Failure	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	0	1		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due of (or as a consequence of)	0.01			
	cuted nd ransit	Examiner	that initiated events	Acute Remal	failure			
60,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):	11 Fred			
68760		edicai		James Los III le	(1,703			
. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
P.0	that the de ted by the a detached		9 ☐ Unknown  Part II. Other Significant conditions con		a underlying cause given in Part I	23e. Did tobacc	o use contribute to th	e cause of death?
ds,	uires tha signed Id be del	d by	("oncestal	Hert Farmer				ably 4 Unknown
COL	iaw require as been siç 2 should b	Completed				24a. Was an autopsy	24b. Were autop	sy findings available
- R		Com				performed 1 Yes 2 X	?   death?	
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Other	th (Check only one)		
of	g Phys er this eral di	n: To	27. Manner of Peath	28a. Date of Injury (Month, Day ear)  28b. Time Injury	of 28c. Injury at	ome 5 Residence 28d. Describe how in		)
sion	Attending ir death. ector: After by the fune	atio	1 Adatural 5 Pending investigation 3 Suicide 6 Could not be	(World, Day 16al) Injury	M 1 Yes 2 No			
Division	after de Direct	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rurai ate)	Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co	29a. Cartifier Certifying Phys	sician: To the best of my knowledge, de her: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	and due to the cause rred at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier		29c. License number	29d. I	Pate signed (Month, L	Day, Year)
	1 ^				D5875	7 1	16/04	
	IVA		30. Name and address of person who co	- 7. 1 1)	e, Print)	Glen Arza	adon	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	h 1	OTCH ALZ	240H	
	Registi	rar	JAN Z I Z	UU4 Const	sporks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. < 2. Date of Death 1. Decedent's Name (First, Middle, Last) ر کے کے Month **Physician** :25 AM JUNE ELIZABETH MUIR 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 06-01-1924 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 5. Sociaf Security Number **Funeral** Months Days Min. 1 □ M 2 🛛 F CONNETICUT 79 Yrs. 218-12-1407 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f shov other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director OCEAN CITY WORCESTER the 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21842 USA or Items 23a 710 142ND STREET Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "neturel", or Ite 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOSPITAL REGISTERED NURSE 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be ADALENA ELIZABETH RASQUINN JESSE HAROLD TOTTEN Jore, M.
Jermit. Pages 1 and 2 sho
Department of Health
Important: If ther
any Injury of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 142ND STREET, OCEAN CITY, MARYLAND 21842 KAREN E. SUTTON - DAUGHTER 710 20b. Place of Disposition (Name of cemetery, crematory or other place) 8-12-20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 01-23-2004 DELMAR, DELAWARE 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Suneral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 ccident Physician CRIBIOUZS(U/II /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2□ No 2 PNo 1 Tyes 1 ☐ Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Platural 5 Pending after death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 - Homicide within 24 hours at To the Funerel C completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date/signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

22400

土

Hece

9733

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Year) 7 2004

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificati	te of Death	R	eg. No. ZUL	14 04 19	3
		1. Decedent's Name (First, Middle, La	st)			2. Dete of Dea Month		3. Time of Death	
	Physician /Medical	THELMA	K	MESSICK		Januar			4
	Examiner	4a Fecility Name (If not institution, give	re street and number)		4b. City, Town, or		4c. County of [		
		Salisbury Rehab 8	Nursing Cent	ter	Salisbu		Wicom	ico	
	Funeral	5. Social Security Number 6. S	Sex 7. Age (In yi	rs. last birthday) If Under	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreig Country)	gn
	Director	215-14-3004	81	Yrs.		March 6		Virginia	
	Pu &	Usuel Residence of Decedent  10a. Stete 10b. County	10c.	City, Town or Location				10d. Inside City Limit	ts
	aho aho	73.75		•				112 Yes 2 □ N	
	r 28a-f show	Maryland Wicomi	.co	Salisbury	Code	1	0g. Citizen of Wha	t Country?	
	urs after death with the Maryland al!, or terms 23a or 28a-f show Examiner must be notified at by Funeral Director	125 Lakeview Dri	110		1804		USA	. country	
	eath me 23		12. Was Decedent Ever in		dent of Hispanic Origin? (S	pecify Yes or No-	American Indien,		
- <del>x</del>	Tun Herd	11. Maritel Status 1 □ Never Married 2X Married	Armed Forces?	If Yes, spe	cify Cuban, Mexican, Puert	o Rican, etc.)		Vhite, etc.	
200	Ir. or	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:	1 ☐ Yes	2☑ No Specify:		Specify:	white	
(A)	within 72 hours atter ane. than "natural", or he he Medical Examina impleted by Fu	15. Decedent's Ed		16a. Decedent's Usu	al Occupation		16b. Kind of Busin	ess/Industry	_
22	be filed within 72 hou tal Hygiene. d other than "nature event, the Medical and Be Completed	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give kind of wo	ork done during most of wor se retired)	rking			
7 2	d with	12	— (1-401 34)	Secretar	Y		Lawyer		
7	a filed other cont.	17. Father's Neme (First, Middle, Last,	)		18. Mother's Nar	ne (First, Middle, I	Maiden Surname)		
<u>ة</u> ج	Menta Menta Irked Itice	William P. Hasti	ngs		Ruth E.	. Shockle	ey.		
Marylan	sho should be made	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Addres	s (Street and Number or Ru	ıral Route Numbei	, City or Town, Sta	te, Zip Code)	
-	and alth	Samuel Messick/hu			view Dr., Sal	* *			
2 e	es 1	20a. Method of Disposition 1 X Burial 2 Cremation 3 C	1	<ul> <li>Place of Disposition (Na cemetery, crematory or cemetery)</li> </ul>	me of other place)	Date	20c. Location - City	or Town, State	
片 E	Peg nent ant: It	4 □ Donation 5 □ Other (Specif	y) S	oringhill Memor	-	1/21/04	Hebron,		
The	permit. Peges 1 and 2 should be filled view bepartment of Health and Mandal Hygin important: If Item 27 is marked other tanny injury or other traumatic event, the bings.  To Be Co	21. Signature of Funeral Service Licer	yset-	22. Name at HOLLO	nd Address of Facility Way Funeral F	lome Prof	essional	Association	1
<u> </u>	80 = 80	Mostle SC A	June 1 CF	分 501 Si	now Hill Rd.	Salisbu	iry, MD 2	1804	
	THE COST	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that Aused the de	ath. Do not enter the mo	de of dying, such as cardiad	or respiratory arr	est,	Approximate Interval Between	
	Physician	Shock, of float failule. Elst only	one cause on account.	7				Onset and Death	
	/Medical	Immediate Cause (Final disease or condition	A 40/00-		D	1 co		6100	
	Examiner	resulting in death)	Due to	(or as a consequence of)				1	
	icate be executed physician end is the burial-trensit		h						
	eath certificate be executed etending physician end for use as the burial-trensit clan/Medical Examír	Sequentially list conditions,	Due to	(or as a consequence of)					
.09	cian cian ourial	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	C						
68760.	physic the t	that initiated events resulting in death) Last	Due to	(or as a consequence of):					
×	Se Se		d						
Bo	at the death c d by the ettenc etached for us Physiclan.								
	the de	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlying o	ause given in Part I.			ute to the cause of death	
0						1 U Y	es 2∟No 3∟	Probably 4 Unknow	wn
ds	signed the day					24a. Was a	n autopsy 2	tb. Were autopsy findings	;
Ď	been shou					perforr	ned?	available prior to completion of cause	
Rec	The law require sate has been si pege 2 should						41.20	of death?	
<u></u>	icate						s 2L/No	1 ☐ Yes 2 ☐ No	_
Division of Vital Records.	Attending Physician: The law requires that the death or death.  sctor: After this certificate hes been signed by the eitence by the funeral director, pege 2 should be detached for use lification: To Be Completed by Physician	25. Was case referred to medical examiner?	Hospital:		Othor	ith (Check only on		Mary	
ō	Physic this or ral dire	1 ☐ Yes 2 ☐ Mo 27. Manner of Death	1 ☐ Inpatient 2	☐ ER/Outpatient 3☐ Di 28b. Time of	A 4 Nursing H		once 6 □Other (5 ow injury occurred	Бреспу)	+
n c	After fune	1 ☐Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		,,		
<u>:S</u>	deat ctor: y the	3 ☐ Suicide 6 ☐ Could not be		home, farm, street, factor	v, office			r Rural Route Number,	-
Š	after Direction	4 Homicide	building, etc. (Spec	city)		City or Towr	n, State)		
_	spital cours serai fille	29a. Certifier 1 Gertifying Ph	ysician: To the best of my kr	nowledge, death occurred	at the time, date end place	, and due to the ca	ause(s) and manne	r as stated.	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		niner: On the besis of examinand manner stated.						
-	To the Withir To the Somp	29b. Signature and title of certifier	1	29	c. License number	2	9d. Date signed (M	onth, Day, Year)	
_			1/1/		0 3 07/	9	11.91		
					0/1/18		9/1///		
		30. Name and address of person who	completed cause of death (It	em 23e) (Type, Print)	10)58		7/1/07		
10DC	λ	30. Name and address of person who william H. R	completed cause of death (Its		ivision St.,	Salisbu	y, MD 2	1804	

DHMH 16 Rev 6/95

The content of the			1	For State Registrar				and / De		nt of H	lealth a		ental Hyg	_	004	04/94
TOTAL PARTIES AND A FACTOR STATE OF CONTROLORS AND A FACTOR STATE	1	والتناوي			fle, Last)										Vanr	3. Time of Death
Familiary    Familiary   Familiary Name of the control plane by the process of th				Carrol1					Mar	shall				23,20		11:55 P™
Total Control   Control				4a. Facility Name (If not institution	on, give stree	et and nu	mber)		4b. Ci	ty, Town, o	Location of	f Death		4c. Coun	ity of Deeth	
Signature   Sign		LAMITIME		1722 Crestwood	d Circ	1e			Sa	lisbu	ıry				Wicom	ico
Director    Constitution   Constitut		Funeral					7. Age (In	yrs. last birtho					8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
The part of the				220-12-0729	1 🖰 M	2∐ F	8	0 Yrs		5 50,0			June 13	,1923		
Company   Comp		2	-				100	City Tourn	r I coation						1	Od Inside City Limits
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N		arylau Bhow	_				100									
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N		Ba-f	2		omico			Salist	<del></del>	** 0.4-				IOn Citizan o	4 What Cour	nto/?
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N		or 2	2						101.		001			7	or withat Cour	my r
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N		ath v	<u>a</u>					-116	12 Wes Da			nin2 (Sp.	oity Vac or No-		ace - Americ	can Indian
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N		er de	nue		1 -	Armed Fo	orces?	in U.S.	If Yes, s	pecify Cuba	an, Mexican,	, Puerto	Rican, etc.)	В		
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N	36	s affe s	Ž L			If Yes, Gi	ve		1 🗆 Yes	2 🔀 No	Specify:			Spec	city: Wh	ite
Power Company   1-12   College (1.4or 5-)   Electrician   18. Monter Name (First Models Assign Summer)   19. Monter N	5	hour literal	ed -					16a. D	ecedent's U	sual Occup	ation			16b. Kind of	Business/In	dustry
Physician Middleal Examiner  Physician Middle	u T	in 72 in 72 in an	Siet	(Specify only high	est grade co	ompleted)		(6	ive kind of le. DO NO	work done use retired	during most d)	of worki	ng			
Physician Medical Examiner of Control Medical Examiner of	2.0	with iene.	E			College	1-401 3+)	E	lectri	cian				Power	Comp	any
Physician Middleal Examiner  Physician Middle	7	Hyg other	9	17. Father's Name (First, Middle	, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sum	ame)	
Physician Middleal Examiner  Physician Middle	2	ked be	0	Clifford			Ma	arshall	L		Esth	er	Amelia	Smith	1	
Physician Middleal Examiner  Physician Middle	Ì	shou and M and M		19a. Informant's Name/Relation	ship (Type,	Print)		19b. M	lailing Addre	ess (Street	and Numbe	r or Rura	I Route Numbe	r, City or Tow	m, State, Zip	Code)
Physician Medical Examiner of Control Medical Examiner of	3	nd 2 alth a 27 is rrtra		June Marshall	- Wife	<u>:</u>		1722	2 Cres	twood	l Circ	le_	Salisbu	ry, MD	2180	4
Physician Medical Examiner of Control Medical Examiner of		S 1 a f	1			.,	20	b. Place of D cemetery,	isposition (/	Name of or other place	ce)		Date	20c. Location	n - City or To	own, State
Physician Middleal Examiner  Physician Middle		Page lent o nt: If				ioval from	State					<b>1–</b> 26-	-2004	Delman	r, DE	
Physician Middleal Examiner  Physician Middle	=	mit.	İ	21. Signature of Euneral Service	e Licensee	11			22. Name	and Addre	ss of Facility	у Вс	unds Fu	neral	Home	
Physician (Medical Examiner)  The proposition of the property	à	a se se a		Million	Res	He	uses	2	705	E Mai	n Str	eet	Salisb	ury, M	ID 218	04
Physician (Medical Examiner)  The proposition of the property				23a. Part. Enter the disease,	or camplicat	ions that	caused lie	death. Do not	enter the n	node of dysr	ng, such as	cardiac o	or respiratory ar	est,		Interval Between
Due to (or as a consequence of):		Physician	d	Immediate Cause (Final	st gilly one c	Ma	tata	ti.	4		(cer	rus			1	Onset and Death
State  State  Sequentially list conditions, which considers the cause of dealth of the caus				resulting in death)	a	Due to	(or as a cor	nsequence of)	:							1 y
The standard overlate sequence of the st		Examiner		O	ь											
The standard overlate sequence of the st			ner	r any, leading to immediate cause. Enter Underlying		Due to	(or as a cor	isequence of)								
State   Stat		cuted	ami	that initiated events	с.											
Second   S	ç	e exe		resulting in death) Last	1	Due to	(or as a cor	rsequence of)	•							
State   Stat	27	ate by hysic he bu			d											
State   Stat	Š	artific ing pl	Med	IF FEMALE:		.,		recount.								
State   Stat		th ce	an/	23b. Was decedent pregnant	23c.	1 Live	birth 2 🗌	Fetal death			/			1		•
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	-	the ar	sic	1 ☐ Yes 2 ☑ No				of death	5 U Other	(specity) _						
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	-	d by	F F		tions contrib	buting to c	teath hut no	t resulting in t	ne underlyin	n cause div	en in Part I.		23e. Did to	bacco use co	ontribute to t	he cause of death?
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Registrar's Signature	9	Signe Bed bed		Part II. Other significant condi	5-F	-ive		t togatting at a	io directiyii	g occord gr			1,01	es 2 No	3 Prol	bably 4 Unknown
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		oro nould	eted	Calar		1/1							24- 345-	104	h 14/2-2- 2-4-	Godines avaleble
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Registrar's Signature	1	law las b	npie	COION	CEV	uer							autop	sy med?	prior to co	impletion of cause of
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		The Cate	ဝွဲ	fulm 2	mbol	11500	<u> </u>								1 🗆 Yes	2 No
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		/ICan cian entificientification		examiner?		nital:				Ott						
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	4	ohysi this c	- 1			1 🗆				DOA	4 L Nu					(y)
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Registrar's Signature		ing P	o	1 Natural 5 Pen	ding	(Mor	nth, Day Yea		iry	Wo	rk?		200. 56301001	ow injury ooc	31100	
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	-	SIC Sicand Seath tor: ) the f	cat	E - 1.00.00	1	ana Plac	e of Injune -	At home farm			143 201	- 2	28f. Location (5	itreet and Nu	mber or Run	al Route Number.
29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Registrar's Signature		or Al	Ţ		mined	build	ding, etc. (S	oecify)	, sileer, lac	tory, onlog						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print),  DAMD GNALL WD 125 E. (ARBILL ST', SALISBURY WD 2180)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		pital purs a eral I	O	29a Certifier	ing Physic	ian: To th	e best of my	/ knowledge	death occur	red at the ti	me, date an	d place	and due to the	ause(s) and	manner as s	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print),  DAMD GNALL WD 125 E. (ARBILL ST', SALISBURY WD 2180)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Hos 24 ho Fun stely	jca	(Check only 2 Medic	al Examine	r: On the l	basis of exa	mination and/	or investigat	tion, in my	pinion, deal	th occur	ed at the time,	date and plac	e, and due t	o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print),  DAMD GNALL WD 145 E (ARBILL ST', SALISBURY WD 2180)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		o the	Me		lief	//	9,			29c. Licens	se number			29d. Date sig	ned (Month,	Day, Year)
State 31. Date filed (Month, Day, Year) 32. Hegistrar's signature		F 3 F 00	-		LE	-	1	MK		D	11	27	8	1.	- 21	-04
State 31. Date filed (Month, Day, Year) 32. Hegistrar's signature				20 Name and address of re-	on who com-	nleted as:	Isa of death	(Item 23a) /T	(De Print)						-0	1-11
State 31. Date filed (Month, Day, Year) 32. Hegistrar's signature	1/+1	JH DQ		DAM CA	MA Z	LU	1)	145	El	ARRIL	L 57	r.,	SA	LISBRI	RY N	ND 2180/
Registrar IAN 2. 7 2004 Geneva & Sparks	0	1 Stat	e	31. Date filed (Month, Day, Ye.	ar)	32.	Registrar's	Signature	1	/		<u></u>			-9	
				JAN 2	7 200	14	Sever	1	9	spour	Es .					

			1 - State Registrar	State of Maryland		artment of H tificate of I			giene leg. No. 2004	04195
			Decedent's Name (First, Middle, Last	)				2. Date of Dea Month		3. Time of Death
	Physici		SUE TATE	MCGRATH				JANUARY	20,2004 Year	1750 M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of	Death	4c. County of Dea	ath
			412 W. College A	ve.		Salisb	ury		Wicomio	0
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I		If Under 1 Year Months Days		4 Hrs. 8. Date of Birth Min. (Month, Day	y, Year) 9. Bi	rthplace (State or Foreign country)
	Director		203-40-1040	<sup>3 M 2</sup> ☑F 72	Yrs.			March 1	1,1931 V	'irginia
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	shor	ក	,							1X Yes 2 No
	Ne N	Director	Maryland Wicomic	O   Sc	alisbu	10f. Zip Code			10g. Citizen of What C	Country?
	with t	ä				,				ountry :
	9ath	by Funeral	412 W. College A	.VC • 12. Was Decedent Ever in U.S	S 13 1	21801	ispanic Origi	n? (Specify Yes or No-	USA 14. Race · Am	erican Indian.
	ter d	Š	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		f Yes, specify Cuba	n, Mexican,	Puerto Rican, etc.)	Black, Wh	
36	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or tems 23e or 28e-f show the M.cdical Examiner must be mailfied at	b	15. Decedent's Edu		16a. Deced	ient's Usual Occup	ation	4	16b. Kind of Business	s/Industry
715	n u	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done of OO NOT use retired	unng most o	or working	,	
212	d with	E O	12	4	exec	itive Sec	retary	7	State Uni	versity
Þ	e file of Hyg vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Middle,	Maiden Sumame)	
<u> a</u>	uld be Aenta rked tic en	ToE	William Carringt	on Tate			Mar	y Sue Dung	an	
Maryland	iges 1 and 2 should be filed within 72 hours atter death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Modical Examiner must be mailtied at		19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Street	and Number	or Rural Route Number	r, City or Town, State,	Zip Code)
	t and 2 Health a tem 27 is		William T. McGrat	h/son	1220	Taney A	Ve., S	Salisbury,	MD 21801	
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - City o	r Town, State
Ë	Pages nent of I int: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)		e Chai	cles Ceme	terv	1/26/04	Cape Char	les, VA
alti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens						fossional	Association
Ä	Depar Impor any ir	(	David 4- Com	DOW CESP	3	501 Snow	Hill R	d., Salisb	ury, MD 21	804
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death	. Do not ent	er the mode of dyin	g, such as ca	ardiac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	NO SEESE ON SEEST INTO.		•	m	erdial and	aliska o	Onset and Death
	/Medical		resulting in death)	a Due to (or as a consequ	uence of):		200	<del></del>		
	Examiner		a series and the series are the series and the series and the series and the series and the series and the series and the series are the series and the series and the series are the series and the series are the series and the series are the series and the series are the series and the series are the seri	b						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that self-steed as each	Due to (or as a consequ	anne of):		-			
	cuted od ransi	Examiner	that suitated events	c.						
ó	an ar rial-t	Ä	resulting in death) Last	Due to (or as a consequ	ence of):					
68760	icate be executed physician and s the burial-transit	dlcal		d						
89	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Jed	IS ESMALS.							1
Вох	leath certific attending p i for use as	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of de Month	elivery Day Year
	ne deal the att hed fo	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown		Other (specify)			Month	Day Feat
P.O.	that the deed by the detached	Physician/Me	9 Unknown					00 8:4:		
	w requires that been signed I should be det	þ	Part II. Other significant conditions co				en in Part I.	/	bacco use contribute t	
ğ	equir en si ould	E G	Hx Vascu	" HBP CO	7657	Marie			es 2 No 3 P	robably 4 Unknown
၁၁	has be	ple						24a. Was a autops		utopsy findings available completion of cause of
Ĕ	The ate ha	Completed						perform 1 ☐ Yes	med? death? 2☑No 1☐Ye	s 2 No
of Vital Records,	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		-		26. Place	of Death (Check only or	ne)	
<b>†</b>	hysic this ce al direc	To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe	er: 4 ☐ Nurs	sing Home 5 eside	ence 6 □Other (Spe	ecify)
	ng Pt ter th	Ë	27. Manner of Death 1.2 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	at c?	2 esc ibe h	ow injury occurred	
Division	endin eath. or: A	Certification;	2 Accident investigation			M 1 🗆	Yes 2 □ No	-		
<u>×</u>	I or Attendi after death. Director: A I in by the fu	Ĭ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
	Hospital or Attending 24 hours after death. Funerel Director: Attentely filled in by the fune	Č								
	tosp t hou une une	cal		rsicien: To the best of my know iner: On the basis of examinat						
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	and manner stated.						
	To To	2	29b. Signature and title of certifier	Deco		29c. Licens			29d. Date signed (Mon	ui, Day, reai)
7						27 406				
D			30. Name and address of person who c	ompleted cause of death (Item	23a) (Type,	Print)	- 440	2.80		
/X			31. Date filed (Mong Ray 2) 20(	102 100 Block	+ 247	* 201112A	<b>.</b>			
	Sta Registr		31. Date filed (Mon A. Ray 2 2 20	32. registrars signal	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	Sparks				

DHMH 17 Rev 1/2001

Registrar

JAN 2 2 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 27, 2004° **Physician** 8:23 P M **JAMES** MONAGHAN **EDWARD** /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Prince George's 8704 49th Avenue College Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days ₩ M 2□F 213-44-5346 57 Aug. 24, 1946 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f show r then "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1√2 Yes 2 No Director Maryland | Prince George's College Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 8704 49th Avenue 20740 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Prince George's Board permit. Pages 1 and 2 should be filed within a Department of Health and Mental Hygiene. important: if item 27 is marked other than ", any injury or other traumatic event, the Mas once. Elementary/Secondary (0-12) College (1-4or 5+) of Education Custodian 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas John Monaghan, Sr. T. Madeline Long 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Ann Denevan -sister 8706 49th Avenue College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 1/29/2004 Alexandria, Virginia 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. Donald UB 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) **Physician** Carcinoma Lung vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Iding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 X No 1 Yes ours after death.

leral Director: After this certific, filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Certification; To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1X Neturel Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 28, 2004 D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devore, M.D. 4203 Queensbury Road Hyattsville, Maryland 20781 31. Date filed (Month, Day, Year) JAN 29 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 06198 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** 10:55 A M January 27 2004 Genevieve Gemma McCadden /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Nursing Home Silver Spring

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🖾 F Yrs. 209-22-1453 75 April 30, 1928 Pennsylvania Director Usual Residence of Decedent death with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County marked other than "natural", or Itama 23a or 28a-f show matic event, the Medical Executer must be notified at 1 XYes 2 No Directo Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12202 Gaynor Road 20852 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: if Item 27 is marked o Bernard Aloysius Burke Genevieve Catherine Barrett item 27 is marke other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Bartholome/Sister 12202 Gaynor Road, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition January 30 permit. Pages
Department of
Important: If it
any injury or once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 2004 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee ole mohle 23a. Part1. Enter the disease, or "omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia 10 days /Medical Due to (or as a consequence of): **Examiner** 8 years Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Diabetes Mellitus 18 years that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician a tached for use as the burial-Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2₺No 3 Probably 4 Unknown bluods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2K No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at to the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 101 D 30844 January 27, 2004 30. Name and address of person who completed cause of death Item James F. McMurry, Jr. M.D., 4761 Randolph Road #103, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 Senew Registrar

		1	For State Registrar	State of	Marylar		artmen rtificat			and M		eg. No. 2	04	04	99
	Physicia /Medic	ın	Decedent's Name (First, Middle, L     DELVAN DEAN MAN								2. Date of Dea		4 <sup>Year</sup>	3. Time of D 8:05P	Death M
j	Examin	er	4a. Fecility Name (If not institution, gi National Insti	tute of I	lealth		Ве	theso					tgom	ery	
	Funeral Director		5. Social Security Number 508-90-6994  Usual Residence of Decedent	Sex 1∭2 M 2□F	'. Age (In yrs. 42	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Birth (Month, Day April 2	, Year 961	9. Birth Cou Wes	place (State or intry) t Point	Foreign , NE
	e Maryland a-f show		10a. State 10b. County Nebraska Dougla	s	10c. Ci	ty, Town or Lo								10d. Inside City ty∏Yes	
	3a or 28	i Dire	10e. Street and Number 11021 Jones Str	eet			10f. Zip	Code 38154	, +		1	0g. Citizen of V U.S		intry?	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedleal Examinating to notified at	by Fur	11. Marital Status  1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1   Yes If Yes, Give Year or Da	ces? 2 🔯 No		Was Dece If Yes, spe			gin? (Spa , Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Amer ck, White		
21215-0036	d within 72 ho giene. or then "natur the Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-	4or 5+)	1	dent's Usu kind of wo DO NOT u Liver	rk done d se retired	turing mos	of work	ing	16b. Kind of Bi		auling	
Maryland	2 should be filed n and Mental Hygin I is marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Las Edwin Mandel	t)					Ve	rona	Liekhus	3			
Mar	1 and 2 sho Health and Iem 27 is m		19a. Informant's Name/Relationship Alyssa Mandel/ W								, NE 68		State, Zi	p Code)	
Baltimore,	Pages 1 and of He Int. If item		20a. Method of Disposition  1   Bunial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec		tate Res	Place of Dispo cemetery, cres surrect	osition (Nai matory or o	ne of other plac Cemet	ery 1			20c. Location - Omaha,			
Balti	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Lic	ensee /	7 MO12		2. Name ar 5130 \			00	seph Gav				016
760,	oath certificate be executed  Attending physician and attending physician and tor use as the burial-transit	icai Examiner	shock, or heart failure. List online mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Res S Due to (c) b. Due to (c) C. Live Due to (d) d. Me	r as a consec	toku	re ne	into	me	- 24	1		4	Interval Betwo Onset and Do 5 Mary 4 day 5 day 5 day	
.O. Box 68	D 0 D	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta untat time of d	aldeath 3[	⊒Ectopic p ⊒ Other (s <sub>f</sub>					23d. Da Mo	te of deliventh	•	ear .
<u>α</u>	uires that the signed by ald be detac	d by Ph	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	ınderiying (	ause give	en in Part I			bacco use cont		the cause of de	
Records,	hysician: The law requires that the his certificate has been signed by th I director, page 2 should be detache	Completed									24a. Was a autops perfor	ned?	Were aut prior to co death?	opsy findings avompletion of car	vailable use of
Vital	Physician: this certific ral director,	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♥ No	Hospital:	patient 2	] ER/Outpatie	nt 3□ D	Othe	ar.		n (Check only on		er (Spec	(fv)	
ion of	Attending Phy if death. ector: After thi by the funeral of		27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date o (Monti	f Injury n, <i>Day Year)</i>	28b. Time o Injury		28c. Injury Work			28d. Describe he				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	286. Place	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, st	reet, factor	y, office			28f. Location (Si City or Town		er or Rui	al Route Numb	θ/.
	e Hospi 24 hour e Funer letely fill	edicai	29a. Certifier 1 Certifying 8 2 Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	th occurred ivestigation	at the tin	ne, date an pinion, dea	d place, th occuri	and due to the cred at the time, d	ause(s) and ma ate and place,	nner as : and due :	stated. to the cause(s)	
		Me	29b. Signature and title of certifier	JU:	£ .			c. License	number H 100	21		9d. Date signer	Month.		
	lo		30. Name and address of person wh			m 23a) (Type,	, Print)		1		0892	1/24	707		
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Sign		2.	uks	-						

			For State Registrar	State o	f Marylar	nd / Depa	artment o	of Health of Death	and Mental	Hygie Reg.		04	200
			1. Decedent's Name (First, Middle	e, Last)					2. Date Mont	of Death	Day Yeer	3. Time of	Death
	Physici: /Medic		Anthony James	Mancuso					Janu	ary 1	19, 2004	6:13	A M
	Examin	er	4a. Fecility Name (If not institution		n <i>ber)</i>			m, or Location			4c. County of Deel	th	
			Holy Cross Hos  5. Social Security Number		7. Age (In yrs.	lest hirthday		Spring Bar If Under	24 Hrs. 8. Date	of Birth	Montgome:	tholace /State	or Foreign
	Funeral Director		100-22-0829	1 M 2 □ F	7.			ays Hours	Min. (Mont	h, Day, Ye	1928 New	York	
	D D		Usual Residence of Decedent				1						
	arylar	٠,	10a. State 10b. County			ty, Town or L	ocation					10d. Inside C	ity Limits 2 X No
	Ba-f	Director	Maryland   Montg	omery	Wh	eaton	10/ 7:- 0	4.		10-	Citizen of What Co		
	with ti	Ö	10e. Street and Number				10f. Zip Coo						
	72 hours after death with the Maryland •natural; or frems 23a or 28a-f ehow odical Examinat must be notified at	Funeral	11708 Highview	12. Was Dece	edent Ever in U	J.S. 13.	Was Decedent	0902 of Hispanic Or	rigin? (Specify Yes	or No-	ited Stat	rican Indian,	
S	after dea or items cirer m		1 X Never Married 2 ☐ Mar	Armed Fo	rces? 2 🗀 No		If Yes, specify (	Cuban, Mexica	in, Puerto Rican, et	c.)	Black, Whit		
رز 5-0036	72 hours after natural', or ite	by	3  Widowed 4 Divorced	If Yes, Giv Year or D	<sup>2□No</sup> ⁄e Korea	a	1∐ Yes 2M∑	No Specify	:		Specify: Whi	Lte 	
200	72 h	Completed	15. Deceder (Specify only highe	it's Education st grade completed)		(Give	dent's Usual Ookind of work do	one during mo:	st of working	16b	o. Kind of Business	Industry (	
3	within iene.	dm	Elementary/Secondary (0-12)	College (1	1-4or 5+)		DO NOT use re trial P		nher	D	esearch		
2 8	filed v Hygie othert		12 17. Father's Name (First, Middle,	Last)		Illuus	LIIAI F		er's Name (First, M				
M. A.	d be antal	To Be	Antonio Mancus						nerine Ca				
J MA	permit. Pages 1 and 2 should be filed within Depurtment of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other treumatic event, the Magnes.	ř	19a. Informant's Name/Relations			19b. Maili	ing Address (St		er or Rural Route N			Zip Code)	
>	and 2 ealth a n 27 le		Mary Theresa M	ancuso/Sis	ster	1170	8 Highv	iew Ave	enue, Whe	aton,	Marylano	1 20902	
Anthony Saltimore, M	of He		20a. Method of Disposition	2 □Removal from		cemetery cre	osition (Name of matory or other	rolace) '	Date January	200	c. Location - City or	Town, State	
im A	Pages ment of than the sant: If the		1 ☐ Burial 2 🂢 Cremation `4 ☐ Donation 5 ☐ Other (5		Cr	ntgome: emator:	ry ium, Ind	c.  2	23, 2004	Ве	thesda, M	arylano	d
alt	permit. Departnimports any nju		21. Signature of Funeral Service	Licensee	190160	R	2. Name and Acockvill	ddress of Facil	Nobert A 300 West 1and 208	A. Pui	mphrey Fu	neral l	Home/
	205 g a		13/12								-87		
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that c only one cause on e	aused the dea ach line.	th. Do not en	ter the mode of	dying, such as	s cardiac or respirat	ory arrest,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	rdial		tion						
	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or as a consec		4					7 8	
	AL.	er	Sequentially list conditions,	b. End S	Stage R	enal D	ısease					4 Year	<u> </u>
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		tensio							10 Year	rs
ć	ate be executed thysician and the burial-transit	Exa	resulting in death) Last	U	(or as a consec								
68760,	ate be hysicia the but	ledical		d									
89	ntifica ng ph	Med	IF FEMALE:	The second	77					_			
Вох	ath cert attendin for use	lan/M	23b. Was decedent pregnant in the past 12 months?		irth 2 Fet	al death 3[	⊒Ectopic pregn				23d. Date of de Month		Year
O.	the a	hysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregn 9☐ Unkno	nant at time of o own	death 5[	Other (specify	y)				,	
P.O.	res that the de signed by the a l be detached t	۵.	Part II. Other significant conditi	ons contributing to de	eath but not re	sulting in the t	underlying cause	e given in Part	I. 23e.	Did tobac	co use contribute to	the cause of o	jeath?
ďs,	signe d be	d by	•	3		•	, ,			1 🗀 Yes	2 🗆 No 3 🗀 Pi	obably 4 🔀	Unknown
20.	w require been si should I	iete		·						Was an	24b. Were as	utopsy findings	available
Re	he lav e has	ompieted			·					autopsy	prior to death?	completion of c	ause of
<u>fa</u>	ystcian: The is certificate hadirector, page	C	25. Was case referred to medica	1				26. Plac	e of Death (Check		No 1 Yes	2 □ No	
<u> </u>	yslciu is ceri direct	0 8	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 25	ER/Outpatie	nt 3 DOA	Other	ursing Home 5	-	e 6 Dother (Spe	cify)	
Division of Vital Records,	ding Ph h. After th funeral	n: T	27. Manner of Death 1 TNatural 5 Pendi	28a. Date	of Injury th, Day Year)	28b. Time o	of 28c.	Injury at Work?	28d. Des	cribe how i	injury occurred		
<u>io</u>	ttendir Jeath. tor: Af the fur	Certification:	2 Accident invest	igation				1 Yes 2					
Ξ	or Att ter de lirect	rtifi	3 Suicide 6 Could 4 Homicide determ	nined 289. Place	of Injury - At hing, etc. (Speci	nome, farm, st	reet, factory, of	fice		tion (Stree or Town, S	t and Number or Ri State)	ural Route Num	ıber,
	pitel ours all		One Continue of M. Continue	an Physician, Tasha	h a st at a l					- 1	-(-)		
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		ng Physicien: To the Exeminer: On the band man									<b>s</b> )
_	o the	Me	29b. Signature and title of certific				29c. Li	cense number		29d.	Date signed (Mont	h, Day, Year)	
	1471		1	188	LIA	el	D11	929		Jan	nuary 20,	2004	
	12.1		30. Name and address of person	who completed caus	se of death (Ite	m 23a) (Type	, Print)						
			David Kessler,					Takoma	Park, MI	209	12		
	Sta		31. Date filed (Month, Day, Year JAN 28	2004 32. R	tegistrar's Sign	ature 4	Span	11					
	Registr	al	טחוז א נ	LUUT	1		MOOR	KS					

			1 - For State Registrar	State of Mary		artment of F			iene og. No.	4 04201
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physici /Medic			LINDIE ED	WARD MAI	LETTE		JANUARY	22, 2004	5:20A M
	Examin		4a. Fecility Name (If not institution, give :			4b. City, Town, o		ath	4c. County of D	
			13105 Taney Driv 5. Social Security Number 6. Sec		yrs. last birthday)	Beltsv:		s. 8 Date of Birth	Princ	Ce George 's Birthplece (State or Foreign
	Funeral Director			M 2□F	75 Yrs.	Months Days	Hours Mi		, 1928 N	orth Carolina
	ŋ		Usual Residence of Decedent						•	
	arylar ehow	_	10a. State 10b. County  Maryland Prince Ge		c. City, Town or L Beltsvil					10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	he M	Director	Maryland Prince Go	sorge s	Deitsvii	10f. Zip Code		1	0g. Citizen of What	
	72 hours after death with the Maryland Instural; or Itama 23a or 28a-f ehow digal Evandrar must be notified at		13105 Taney Drive			Tot. Zip Code	20705	, '	United S	
	me 23	Funerai	11. Marital Status	12. Was Decedent Eve		Was Decedent of H	ispanic Origin?	(Specify Yes or No-		merican Indian,
9	or Ita	Fur	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes — ※☐ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	erto Hican, etc.)		/hite, etc.
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				1		White
15-	n 72 h "nati	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	rorking	16b. Kind of Busine	ess/Industry
12	iene. r than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		et Maker	,		self emp	loyed
þ	il Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, I		
/lar	2 should be and Mental is marked c	ToE	Wilford Herman I	Mallette			Margai	urite Vir	rginia Sla	aughter
Maryland	2 she and ls my		19a. Informant's Name/Relationship (Ty Mary Frances Malle					Rural Route Number ltsville,		
e, P	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, it is Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of Dispo		TIVE DE.	1000000	20c. Location - City	
nor	ages int of li		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	matory or other place ashington	·		Adelphi, 1	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra	12.5	21. Signature of Funeral Service Licens			_				
ñ	Depa Impo eny i		Donald 4,15	newardt	44	onald V. 00 Powder	Borgwar Mill R	dt Funera. oad Belts:	L Home, P ville. Ma	.A. ryland 20705
	46		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death. Do not en	ter the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Assura	tion Pi	Veumor	na			Onset and Death
in the second	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		C 10	. 0		
Fb	LXummer	٦.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):	ene-	Swall	owing De	Sorden	
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Diction	F. M.	ellitus				
Ć.	be executed sician and buriat-transit	Exa	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760	cate be executed physician and the burial-transit	icai		1						
9	artifica ing ph e as ti	Physician/Medical	IF FEMALE:				10 1717			-
Box	eath certific attending pl for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	to the de tached tached to	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time 9 Unknown	e or death 5 (	Other (specify)				
<u>α</u>	de de		Part II. Other significant conditions con	tributing to death but n	ot resulting in the t	ınderlying cause gıv	en in Part I.	23e. Did tot	pacco use contribut	e to the cause of death?
of Vital Records,	quires in sign uld be	ed by	Cornary a	interny De	Sear			1 □ Y€	s 2 □ No 3 □	Probably 4 Donknown
000	law requir as been si 2 should	piet	Hypertense	vi				24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of
R		Completed	11					perform	ned? 🍃 💢 deati	to completion of cause of 1? /es 2□ No
/ita	certifica rector.	Bec	25. Was case referred to medical examiner?					eath (Check only on		
of V	Phyaician: this certific ral director.	2	1 ☐ Yes 2 ☐ NO		2 ER/Outpatie			Home 5 Theside		Specify)
	ling After Tune	ion:	27. Manner Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	par) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe no	w injury occurred	
Division	ten leat tor: the	fical	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, st					Rural Route Number,
Div	al or /	Certification;	4 Homicide	building, etc. (S	Specify)	,,		City or Towr	n, State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physical Exami	sician: To the best of m	y knowledge, deal	h occurred at the tir	ne, date and pla	ce, and due to the ca	ause(s) and manner	r as stated.
	To the H within 24 To the F complete	Medical	one)	and manner stated						
)	vit To Con	2	29b. Signature and title of certifier	0.0		29c. Licens	2840		9d. Date signed (M	In L
	4		1) y sagu	, MP	(lan 200) (T		07		' John de J	T
	1		30. Name and address of person who co Hazel Tape, M.D				ver Spr	ing Marvi	and 2000.	4
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	/	· · · · · · ·	y, naryi	-aiia 2030'	1
	Regist	rar	JAN 2 9 20	04 Jener	2	Spark	21			

			1 - For State Registrar	State of M	larylar	-	artmen rtificat					iene	004	042	202
	Di da		1. Decedent's Name (First, Middle, La	st)							2. Date of Deat Month		Voor	3. Time of D	Death
	Physici /Medio		Doroth	y McGlothl	lin M	cCarde	11				Januar	y 27,	2004	12:15	j a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give				4b. City,		Location of			4c. Co	ounty of Death		
			Residence: 1066	Liberty G	cove	Road			owing				Ce	cil	
	Funeral		,	Sex 7.A 1□M 2ᡚF		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or ntry)	Foreign
	Director		214 20 3032	2.4	71	Yrs.					May 1,	1932	M	laryland	1
	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City	v Limits
	/anyl	5	Maryland Cec	; 1		•		Con	owing	7.0				1 ☐ Yes	•
	the tage	ect	10e. Street and Number	T.T.			10f. Zip		OWIIE	50	10	Og Citíze	n of What Cou	ntry?	
	with Se or	<u>ā</u>	1066 Liberty Gro	ve Road					1918			<b>.</b>	U.S.		
	His 2:	Funeral Director	11. Marital Status	12. Was Deceden	Ever in U	l.S. 13.1	Was Deced			gin? (Spe	ecify Yes or No-	14.	Race - Ameri		
رم	r Iter	돌	1 ☐ Never Married 2 ☒ Married	Armed Forces 1 ☐ Yes 2 ☒	No						ecify Yes or No- Rican, etc.)		Black, White	etc.	
සු	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2∭ No	Specify:			Sp	ecify:	Vhite	
5	72 hours after death with the Maryland Insture!; or Items 23e or 28e-f show Joal Exacilizer ment be notified at	Completed by	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Deced (Give life.	dent's Usua kind of wor	l Occupa	ation Juring mos	t of work	ina		of Business/Ir	ndustry	
2	within ene. than "	d d	Elementary/Secondary (0-12)	College (1-4or	5+)								ey Inn	1	
7	e filed within al Hygiene. I other than '		Twelve Years			EXE	ecutiv	7e H					rk, De	laware	
E C	be find H	Be	17. Father's Name (First, Middle, Last	H. McGlot	h1 ! m				18. Mothe		(First, Middle, N				
3	should be nd Mental n marked o umatic eve	ဥ			.111.111	401-14-11		(2)			ra Belle				
Maryland 21215-0036	nd 2 st lith and 27 Is n traun		19a. Informant's Name/Relationship ( Melvin R. McCarde				•				a <i>l Route Number,</i> d, Conow	•		,	1918
e,	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, Ite McJical Exercities invalide to the colling and		20a. Method of Disposition	zii, 31.	20b. F	- Table 100 - 100					-		tion - City or T		1910
ğ	ages nt of :: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐		, U	Place of Dispo	natory or o	her place	9)						
Baltimore,	it. Partment rtent rtent		<ul><li>4 □ Donation 5 □ Other (Special</li><li>21. Signature of Funeral Service Lices</li></ul>		па		. Name an				9/04 <u>L</u>	ibert	y Grov	e, Mary	yland
Ba	permit, Pages 1 an Department of Heal Importent: If item 2 any injury or other <u>once</u> :		Thomas M.	atterno	x, 5	Lo Po	ee A. erryv	Pat	terso Mar	n & ylan	Son Fune d 21903	eral 3-076	Home,	P.A.	
п			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each	d the deat line.	h. Do not ent	er the mod	of dying	g, such as	cardiac o	or respiratory arre	est,		Approximate Interval Between	een
4	Physician	š lij	Immediate Cause (Final disease or condition	. MYN	aln	it to							1	Onset and De	atn .
н	/Medical Examiner		resulting in death)	Due to for a	s a conseq	juence of):									,
	Lxammer		Sequentially list conditions,	b	M	<i>\( \)</i>							-	5 W	
10	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	CO eq	uence of):	VSecure 2	100	/					air	/
$K_{2}$	and I-tran	хап	that initiated events resulting in death) Last	c. Due o (or as	a consec	uence of):	UVIL	No						7 W	/
8760,	ate be executed hysician and the burial-transit	ical E		200 0 (0, 0,	- u 001100q	1401100 01).									
	.5 5 0			_ d											
Box 6	eath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy						234	. Date of deliv	90/	
ă	that the death cer ed by the attendin detached for use	clar	in the past 12 months? 1 □ Yes 2 ⊠ No	1⊡Live birth 4⊡Pregnant a			Ectopic pro Other (sp						Month	Day Ye	ar
P.O.	it the di by the tached	hysi	9 Unknown	9□ Unknown											
	requires that the een signed by th hould be detache	by PI	Part II. Other significant conditions of	contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use	contribute to t	he cause of dea	ath?
rds	quire n sig uld b	De 1	Detression								1 ☐ Ye	s 2 X	lo 3□Prot	ably 4 □Un	known
00	> 4	jet									24a. Was an	2	4b. Were auto	psy findings av	vailable
æ	The lav	Completed									autopsy	ed?	death?	mpletion of cau	use of
ta		Be C	25. Was case referred to medical						26. Place	of Death	1 Yes 2		1 🗆 Yes	2□ No	
⋛	Physicien: r this certific ral director,	To B	examiner? 1 □ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatien	t 3 DO	A Othe			ne 5∭ Resider	-	Other (Special	v)	
0	g Phys ter this neral dii		27. Manner of Death	28a. Date of Inj (Month, Da	ury av Year)	28b. Time of Injury	2	3c. Injury Work			28d. Describe how			,,	
Ö	ath. ath. r: Afr	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	.y / Ou//	IIIIJary	М		es 2 □!	No					
Division of Vital Records,	or Attending after death. Director: After in by the funer	ţţ	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		jury - At ho	ome, farm, str	et, factory	office		2	28f. Location (Str. City or Town,		u <i>mber or Rura</i>	I Route Numbe	ar,
Ö	talon rs aft el Di	Certification;					_					0.0,			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Pt (Check onty one) 2 Medical Exar	nysician: To the best niner: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	d place, a th occurre	and due to the ca ed at the time, da	use(s) and te and pla	d manner as s ice, and due to	tated. the cause(s)	
	To the within To the Comp	Σ	29b. Signature and title of certifier	.//4 157	ΛΔι	0	290	License	number	^	29	d. Date si	gned (Month,	Day, Year)	
)			XI MITTUR	WW 11	U) PN	<b>V</b>		yu	-816	U		112	104		
	8	1	30. Name and address of person who PETR HAUS NEW	completed cause of 2 MD, 22.	Soul	n 23a) (Туре,	Print)	(hoo.	et i	10	lt; mae	M	), 212	201	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	iture		31000	1		V :	1	1		
	Registr	aı	JAN 2 9 20	U4 parties	Read with	Car State of the state of	STEEL STEEL								

State of Maryland / Department of Health and Mental Hygiene 04203 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 1, 2004 **Physician** 3:43 AMM Tan L. Morrison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Ceci1 **Elkton** 44 AJS Court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□F 17 Pennsylvania 1986 Director May 17, 217-31-8350 death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County tiem 27 is marked orbs than "naturel", or iteme 23a or 28a-f show other treumatic event, the Medical Examinar must be I willied at 1 ☐ Yes 2 No Directo MD Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 USA 44 AJS Court Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be lifed within rartment of Health and Mental Hygiene. ortant: If item 27 Is marked other than injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Student 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Heather H. White Phillips L. Morrison, III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 44 AJS Court, Elkton, MD 21921 Phillips L. Morrison, III/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 02/02/04 \* 4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co. West Chester, PA 21. Signature of Funeral Service Licenses permit. 22. Name and Address of Facility 259 E. Main Street Andrew G. Gee Funeral Home, dwar 7 Keoun PA Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lesticular **Physician** Mostastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cate has been significated to page 2 should to 24a. Was an 2 1 No 1 ☐ Yes or Attending Physician: director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mann Death 28b. Time of Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of entifier, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tha tos tor MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar FEB n 2

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1700 **Physician** January 23, 2004 Anna Rose Moore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Chestertown Kent Chester River Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/11/1911 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F 137-09-7669 92 Yrs. Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show is marked other then "natural", or items 23s or 28s-f show sumstic event, the Mazical Examinat must be retified at 1 ☐ Yes 2 ☐ No Director Maryland Millington Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 32107 Millington Road 21651 USA by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 € Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f John DelFemine Concetta Cinquegrana 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 ie m sny injury or other traum once. Ann B. Vogt/Daughter 32103 Millington Road, Millington, MD 21651 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 1/29/2004 Mt. Holly, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Pint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Fellows, Helfenbein & Newnam Funeral Home, P.A. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL FAILURE days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) week Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner 17 weeks NELUENZA The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physiclan/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o Month Day Year in the past 12 months? 5 Other (specify) been signed by the a should be detached f Yes 200 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2. No 3 Probably 4 Unknown HEART FAILURE 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2 200 1 ☐ Yes Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2,5€No s after death.

I Director: After this of in by the funeral di 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel or within 24 hours aft To the Funeral Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0041587 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 Speer Road, Chestertown, MD 21620 Helen A. Noble 31. Date filed (Month, Day Year) 2 8 2004 32. Registar's Signature State Registrar

			1 - For State of Maryland / Dep	eartment of Health and Mertificate of Death		ene 2004	04205
	m3 15 15	4	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Ellen R. Nichols			22, 2004	11:48 p <sup>M</sup>
	Examin	- 0.	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		37.48	Crofton Convalescent Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Crofton  () If Under 1 Year   If Under 24 Hrs.	R. Date of Birth	Anne Ar	
120	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 218-12-7140 7. Age (In yrs. last birthday 7. Age (In yrs. last	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birti	nplace (State or Foreign untry) MD
46			Usual Residence of Decedent		Aug. 20,	1525	
	how		10a. State 10b. County 10c. City, Town or L 10c. City, Town or L	ocation Crofton			10d. Inside City Limits
	ith the Marylan or 28a-f show	cto			<del></del>		1 ☐ Yes 2 ☑ No
	23a or 2	Funeral Director	2131 Davidsonville Road	10f. Zip Code 21114	10g	J. Citizen of What Co USA	•
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Marical Evandual than the mailing at	by	11. Marital Status  1 Never Married 2 Married  1 Never Married 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
5-0	natu Ikal	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring 16	b. Kind of Business/l	ndustry
121	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ccounting Clerk		Medica	re
2	filed v Hygie other t	ပ္	12 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	To Be	Walter J. O'Malley		ed Lanaha		
	and 2 sh salth and n 27 is m		Patricia E. Nichols/Daughter 304	ling Address (Street and Number or Rur B Gatehouse Lane,	Odenton,	MD 2111	3
3altimore,	Page nent c ant: If arry or		'4 □Donation 5 □Other (Specify)	ematory or other place) ven Cemetery	2004	Glen Burn	nie, MD
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Furgeral Service Licensee	22. Name and Address of Facility Barranco & Sons, P 495 Gov. Ritchie H	.A. Sever wy, Sever	na Park Fi na Park, l	uneral Home MD 21146
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
8760,	centificate be executed and adding physician and as the burial transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Deficit (or as a consequence of):  Deficit (or as a consequence of):  Deficit (or as a consequence of):	r Pneumon e CondioVase	ular D	iseen	years.
89	ificati g phy as the	edle	V.				
O. Box	death e atter id for t	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	89 G 99	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute lo 2 No 3 □ Pro	
Records,	law as b	Completed			24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?	26. Place of Deal	h (Check only one)		
of V	Physic this ce al dire	2	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 Resident	ce 6 Other (Spec	city)
п 0	ding Ph. h. After the		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
sio	Attending Physician: r death. ector: After this certific by the funeral director,	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	2011		18 1 1
Division	tal or At rs after d al Direct ed in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town,	et and Number or Ru State)	ral Houte Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within 2 To the complei	Σ	29b. Signature and title of certifier  Rakesh and 19 M	D 2010		Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Type		<u> </u>		
			Rakesh Arora, M.D., 14300 Gallant Fo	ox Lane, Bowie, MD			
	Sta Regist	ate . rar	31. Date filed (Month, Day, Year)  JAN 2 6 2004  32. Begistrar's Signature	Louis			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 0 4 2 0 6 Certificate of Death 2. Date of Death 3. Time of Death 2004 6:40 pM

1. Decedent's Name (First, Middle, Last) **Physician** John T. Nick Jr. January 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1<del>/</del>2 M 2□ F Director 214-40-6752 16 1943 Maryland 60 April Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Directo Marvland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1714 Carriage Lamp Court 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1967-83 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2☐Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th 0 Factory Worker GROCCO Co. permit. Pages 1 and 2 should be fil.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
eny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John T. Nick Sr. Rosetta Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Nick (Wife) 1714 Carriage Lamp Ct. Severn, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cemétery 1/29/04 Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zang M., Acese Moo483 Wm. Reese & Sons Mortua 821 West St. Annapolis

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Exami Due to (or as a consequence of): 68760, the attending physicien Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a o 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Month

Cardiac Arrest Hypertension, CVA

24a. Was an autopsy performed? res 2 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

Birthplace (State or Foreign Country)

USA

21144

Approximate Interval Between Onset and Death

14. Race - American Indian, Black, White, etc.

specify: Black

Md.

10d. Inside City Limits DOYes 2 No

25. Was case referred to medicat examiner? 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Spylems

Allending

D42580 1 - 23 - 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.S. Aujla Attending 31. Date filed (Month, Day, Year JAN 2 8 2004

5632 Annapolis Rd. #13 Bladensburg, Md. 20710 Registrar's Signature

State Registrar

Completed

Be

2

Certification:

been

certificate

this After thi

To the Funeral Director: /

death.

hours after within 24 hours a

Division or Attending page 2

director.

DHMH 17 Rev 1/2001

-16-1943

5

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ZU 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer WAYLAND OTIS NUTTER January 13 2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Janokin Manor Princeds Anne If Under 24 Hrs. Hours Min. 1 2/25/20 Somersel 5. Social Security Number 6. Sex **X**□ M 2□ F If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign MD Days 77 218-20-7838 Yrs. Usual Residence of Decedent 10a. State 10b. County WICOMICO 10c. City, Town or Location 10d. Inside City Limits MD BIVALVE 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3678 TEXAS RD 21814 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, elc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DUPONT EMPLOYEE DUPONT CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT MCKINLEY NUTTER WILLOW BARCLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ARSEMUS NUTTER SON 3678 TEXAS RD BIVALVE, MD 21814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ELSEY CHURCH CEMETERY 1/24/04 BIVALVE, MD M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MESSICKOOFUNERAL HOME PO BOX 61 M00416 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) SEPSIS CEREBROVASCULAK ALLIDENT 2 WKS Due to (or as e consequence of) LUNG CANCER 2 years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 28d. Describe how injury occurred 1 Natural

attending physician for use es the burie death certificate be ed by the a certificate has been signed irector, page 2 should be del director,

Examiner Physician/Medical ģ Completed Be ဥ After this funeral Medical Certification: filled in by the

2 Accident

3 Suicide

29a. Certifier (Check only one)

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

ပ

**Funeral** 

Director

72 hours after death with the Marylend

2 should be finend Mentel His marked of

permit. Pages 1 and 2.s Depertment of Heelth er Important: If item 27 is any injury or other trau

**Physician** 

/Medical

Examiner

Maryland 21215-0020

Baltimore,

Manolan Manin

3

10

SUCIONS

Records, P.O. Box 68760, Naylana Notta Division of Vital ie Hospital or Attending n 24 hours effer death. ia Funerel Diractor: Aft To the Hospl within 24 hou To the Funer completely fil

State Registrar

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 Mah 0057359 January 14th 2004

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

SALISBURY, MD 21804

DR. NATESON 1415 - S. DIVISION ST 31. Date filed (Month, Day, Year) JAN 2 3 2004

32. Degistrer's Signature

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State
Registra AVEND#28a - fperME1/30/04, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 24 2004 HULLANG Edward Joseph Nolan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** 3703 Warner Avenue Bulle 6-cores If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 31, 1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1**3**M 2□F Yrs. 47 Michigan 219-64-4093 Aug. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
ant: if item 27 is marked other than "neturel", or iteme 23a or 28a-f show try or other traumatic event, The Medical Engin ar market callilies at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Hyattsville Maryland Prince George's Direct 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 20784 3703 Warner Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A 4 Unemployed 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 is marked Kathleen M. Donovan Gerald B. Nolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen D. Nolan/ Mother 12602 Edelmar Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 29 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2004 Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee Inestacietaries 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -ANBING Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Joj. Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only ope) funeral director Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Pes 2 No Certification: To After this 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2√2 No death. Hung himself from a pire 2 Aceident Jan. 24, 2004 1300 filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 3703 Warner Ave; Hyattsville, MD Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar SALVADO Syl
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

30

3004

32. Registrar's Signature

Hos

26, 2004

JANUAYZ

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F			ene g. No. 2001	04209
	Physici		Decedent's Name (First, Middle, Last)     COSTEL:	LO A.	NELSON,	Sr		JAN. 24	Day 200 4 ear	3. Time of Death 9:40 AM
j	/Medio Examir		4a. Facility Name (If not institution, give s Suburban Ho	reet and number)			r Location of Death		4c. County of Dea MONTGON	th
	Funeral Director		210-20-1700 -	M 2□F 7. Age	(In yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 28	Year) ,1923 M	thplace (State or Foreign ountry) aryland
	e Maryland Ba-f ehow	Director	Usual Residence of Decedent		10c. City, Town or Lo Si	lver Sp	ring			10d. Inside City Limits 1 ☐ Yes ※XXNo
	th with th		10e. Street and Number 14208 Grand Pr	e Road,	#A-1	10f. Zip Code 20	906	10	lg. Citizen of What Co U.S.A	
036	d within 72 hours after daath with the Maryland jiana. r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1. 1 Yes 2 □ No If Yes, Give Year or Dates:	)		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
Maryland 21215-0036	within 72 hor ana. then *naturi he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6 th	ation	16a. Decec (Give life. I	dent's Usual Occup kind of work done DO NOT use retired ndscape	during most of wor d)	king	6b. Kind of Business. Goddard Center	
/land 2	s 1 and 2 should be filed within f Haalth and Mantal Hygiana. Itam 27 is marked other than othar traumatic evant, tra M	To Be Co	17. Father's Name (First, Middle, Last)  Clifton Nel	son			18. Mother's Nam F10	ne (First, Middle, M	laiden Sumame) imms	
, Mar	is 1 and 2 sho of Haalth and Itam 27 is my othar traumy		19a. Informant's Name/Relationship (Type Lovella Blantor		ter) 12	805 Tou		Ct., S	ilver Sp	zip Code) 20904 ring, MD
Baltimore,	Page nanto		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  4 □ Denation 5 □ Other (Specify)		Gate of	natory or other plac Heaven	Cem 1/	31/04		Town, State pring, MD HOME, P.A.
Bal	permit. Dapartn Importe any Inju	0 0	21. Signature of Funeral Service License	rouder	4 /2. 2	46 N. W	ash. St	., Rock	ville, M	D 20850
1	Priysician /Medical Examiner	05	23a. Part1. Enter the disease, or complic shock, or year failure. List only on Immediate Cause (Final disease or condition resulting in death)	Massiv	ne geath. Do not ent 7e Gastro consequence of):					Approximate Interval Between Onset and Death Hours
3760,	ata ba executad hysician and iha burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
.O. Box 68	at tha daath certificate by by tha attending physi Itached for usa as tha b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	quiras that in signed t uld ba dati	þ	Part II. Other significant conditions cond Coronary Myocar	-	-				accouse contribute to ; 25⊈No 3 □ Pr	o the cause of death?
of Vital Records,	Tha law raquiras that tha sata has baan signed by th paga 2 should ba datache	Completed	Atherosclerotic	Occlus:	ive Dise	ase		24a. Was an autopsy perform	24b. Were au prior to death? ☑ No 1 ☐ Yes	topsy findings available completion of cause of
f Vita	ysician: s cartific director,	To Be (	25. Was case referred to medical	ospital: 1			er: 4 🗆 Nursing H	th <i>(Check only one</i> ome 5 ☐ Resider	) nce 6 □Other (Spe	cify)
$\subseteq$	a fine		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injun Wor M 1 □	yat k? Yes 2 ⊡No	28d. Describe how	v injury occurred	
Division	To the Hospital or Attendi within 24 hours aftar daath. To the Funaral Director: A complataly fillad in by tha fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc.				City or Town,		
	he Hosp in 24 hol he Funa plataly fi	edical	29a. Certifier (Check only one)  2 Medical Examin	cian: To the best of er: On the basis of e and manner state	xamination and/or inv	estigation, in my o	pinion, death occur	rred at the time, da		to the cause(s)
•	or William P	Σ	29b. Signature and title of certifier	Theye	D		e number 8 9 4 4	29	Jan. 27	h, Day, Year) , 1904
			30. Name and address of person who cor Martin C. Shar	gel, M.	D. 3720	Farrag	ut Ave.	, Kensi	ngton, M	D 20895
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 3 0 200	32. Registrar	's Signature	Specks				

			1 - For State Registrar	State of Mar		artment of Hertificate of C			giene 200	04210
į	Physici	an	Decedent's Name (First, Middle, L.	ast)				2. Date of De Month	eath Day Yeer	3. Time of Death
	/Medi		ARTHUR	WALI	OORF	NELSON	JR.	Tanvari		
7	Examir	ner	4a. Facility Name (If not institution, g	And the same of the same of		4b. City, Town, or		th	4c. County of De	
	F		Upper Chesape  5. Social Security Number 6.		ln yrs. last birthday)	If Under 1 Year	l Air	8. Date of Bir		ford
1	Funeral Director		212-38-0586	1 <b>0</b> M 2□F	63 Yrs.	Months Days	Hours Min.		ly, Year)	rthplace (State or Foreign country)
	P .		Usual Residence of Decedent			11		1 10/11	[/ 1 9+0   N	aryland
	arylar show	_	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits
	he M	Director		ork			Freed	om		1 □Yes 2 No
	with t		10e. Street and Number	D - 3		10f. Zip Code	7.674.0		10g. Citizen of What C	
	leath	eral	4219 Bowser	Road  12. Was Decedent Eve	arin IIS 13 1	Was Decedent of His	17349	Specific Ves or No	United S	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If flem 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event, the Medical Example or must be notified.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Amed Forces?	1	Was Decedent of His f Yes, specify Cuban I □ Yes 2 No	Specify:	to Rican, etc.)	Specific	
9	72 ho	ted	15. Decedent's I	Education	16a. Deced	lent's Usual Occupat	tion		16b. Kind of Business	
21	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done du DO NOT use retired)	uring most or wo	rking		
2	led w lygier her th	Ö	12	4		Accour				fense
and	be fill H of other	Be	17. Father's Name (First, Middle, Las	,			18. Mother's Nar	me (First, Middle,	, Maiden Sumame)	
<u>≅</u>	should ind Men ind Men ind Men ind Men	ဥ	Arthur War 19a. Informant's Name/Relationship	aldorf	Nelson		Anna		Louise	Ely
Sa	d 2 s th an t7 ls r treur		The state of the s						er, City or Town, State,	
altimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then any injury or other treumetic event, Item No. 20108.		Kristin L. Bo	□Removal from State	20b. Place of Dispo- cemetery, cren	natory or other place,	)	Date	20c. Location - City or	
Baltir	permit. F Departme Importen any injur		21. Signature of Funerial Service Lice		ا مر ' از	. Name and Address	Jacob Facility Ja	arretts	ville, M	d, Marylan aryland
			23a. Part1. Enter the disease, or cor	inplications that caused the	e death. Do not ente	or the mode of dving.	such as cardia	or respiratory ar	rest. Hom	P A Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	ULTI OF	26AN FI	AILUA	E		Interval Between Onset and Death
	Examiner			Due to (or as a co	orisequence or).	SEPSIS				I month
•	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):	PNEUMO	ONA	-		1 month
8760,	cate be executed ohysician and the burial-transif	dical Exa	resulting in death) Last	Due to (or as a co			ISEASI	***		1 month
Box 6	eath certific attending p for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P.O.	it the d by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		Caror (apocny)				
	w requires that been signed I should be det	Completed by P	Part II. Other significent conditions SEPSIS PNEVA	contributing to death but no	ot resulting in the un $J-5T$ $ACC$	derlying cause given	in Part I.	23e. Did to	obacco use contribute to	V:
eco	e lawre has ber je 2 sho	plet	ISCHEMIC BOW	EL LIVER	015BASE	ASCITE	:S,	24a. Was a		utopsy findings available completion of cause of
<u>=</u>		S	ALCOHOL ABUS	E.				perfor	rmed? death? 2∰No 1 ☐ Yes	
Vita	iclen: Certifical	Be	25. Was case referred to medical examiner?	Hospital: V			-	th (Check only or	ne)	
of	hys his	10	1 Yes 2 No 27. Manner of Death	1-inpatient	2 ER/Outpatient		4 Li Huising H		lence 6 Other (Spe	cify)
5	ding F h. After funera	to Lo	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	es 2 □No	28d. Describe h	ow injury occurred	
Division of Vital Records,	l or Attending after death. Director: After i in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Diagonia	- At home, farm, stre Specify)		2 110	28f. Location (S City or Tow	Street and Number or Ro n, State)	ural Route Number,
_	Hospi 4 hou Funer tely fill	Medical C	29a. Certifier (Check only one)  Certifying P  2 Medicel Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	amination and/or inv	occurred at the time, estigation, in my opin	, date and place nion, death occu	, and due to the c rred at the time, c	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	6 0		29c. License r	number		29d. Date signed (Mont	h, Day, Year)
	10		30. Name and address of person who	completed cause of death	(Item 22a) /Time 5	H-E	09432	5	JANUARY	20, 2004
			31. Date filed (Month, Day, Year)	M- BYRVE  32. Registar's	0.0-		MPER CI	HEJA PE	AKE BEL	AIR, NO
	Sta Registr		JAN 2	3 2004 See	signature &	Soule				

			1 - For State Registrar	State of M		d / Depa	artme	nt of H			ental Hy		2001	04211
	Physici /Medic		Decedent's Name (First, Middle, Lass     MARIE MAE OWENS	st)							2. Date of De Month 01	ath Day 21	, Yeer 2004	3. Time of Death
	Examin		4a. Fecility Name (If not institution, give PENINSULA REGIONA 5. Social Security Number 6. S	AL MEDICAL	CEN	TER last birthday)		SALIS er 1 Year	If Under:	24 Hrs.	8. Date of Bin	th	WICOMIC 9. Birth	
€* 'e '*	Funeral Director			□м 2ДТ	77	Yrs.	Months	Days	Hours	Min.	05-21-	1926	EDE	N, MARYLAND
	n 72 hours after death with the Maryland "natural", or ltems 23e or 28e-f show spicel Exerciting mass be reculfied at	ector	10a. State         10b. County           MD         WICOMI           10e. Street and Number	CO		y, Town or Lo	RY	ip Code				10g Citi	izen of What Co	10d. Inside City Limits 1 ☐ Yes ※☐ No
	eath with 18 23a or mart be t	Funeral Director	706 SCHUMAKER LAN	E 12. Was Deceden	t Ever in U.	S. 13.	2	1804	ispanic Orie	ain? (Spe	cify Yes or No		USA	
		b	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2 7  If Yes, Give X  Year or Dates	?  No		1 🗆 Yes	2€ No	Specify:		cify Yes or No Rican, etc.)		Black, White	a, etc.
7-0171	filed within 72 hours after Hygiene. stherthan "natural", or Ita ent, Ira Medicu Exertire	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2	lucation de <i>completed)</i> College (1-4or	5+)	16a. Dece (Give life.	dent's Us kind of w DO NOT EMAKE		ation during mosi f)	t of workir	ng		ind of Business/I	ndustry
=	a da b	To Be Co	17. Father's Name (First, Middle, Last) SAMUEL GARDNER WI			110111			18. Mothe		(First, Middle,			
Mar	and 2 should alth and Men 1 27 is marke er treumatic		19a. Informant's Name/Relationship ( DEBBIE HENRY -	Гурв, Print) -DAUGHTER		8388	HILD	A DR	IVE, SA				AND 218	
Baitimore	permit. Pages 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		1 1	Place of Dispo emetery, crer MATORY					2-2004		CAR, MAR	
Dail	Departi Departi Imports any inji		21. Signature of Euneral Service Licenters	as He	ang	7	05 E	CAST 1	MAIN S	STREE	ET,SALI	SBUR	L HOME, Y,MARYL	AND 21804
	Physician /Medical		23a. Part . Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each  a		EMP			g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a										
-	ate be executed hysician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	s a conseq	uence of):								
O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	⊒Ectopic ⊒ Other (:	pregnancy specify)	,				23d. Date of deli	very Day Year
cords, P.	requires that t een signed by hould be deta	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying	cause giv	en in Part I.			4		the cause of death?
H He	The larate has	Completed									24a. Was autop perfo 1 Yes		prior to c death?	copsy findings available ompletion of cause of
VITAI	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or		(Check only o			
on or	Phy this ral d	tion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		28c. Injur Wor	4 🗀 140	2	ne 5 🗌 Resid 8d. Describe		6 Other (Spec y occurred	ify)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At ho atc. <i>(Specif</i>	ome, farm, str y)	reet, facto	ory, office		2	8f. Location (S City or Tox			ral Route Number,
	he Hospit in 24 hour ihe Funer pletely fill	Medical	29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exer	ysicien: To the bes niner: On the basis and manner s	of examina	wiedge, deat tion and/or in	h occurre vestigatio	d at the tir on, in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ad at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier				2	9c. Licens	e number				e signed (Month	
			24 Nata		42.4	- 00-1 7	D-: -:	D	0513	59		Jan	215+ 21	004
D	Q		30. Name and address of person who					y ^	1020	404				
, A. 150	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 2 20	04 32. Fegis	trar's Signa	ature &	Sp	racks						1

		•	1 - For State Registrar	State of Marylan		artment of H			giene 2	004	04	218
0	= 1		1. Decedent's Name (First, Middle, Las	t)		-		2. Date of Dea	ath Day	Year	3. Time of I	Death
	Physicia /Medic		Theresa Lynn	e Olson				January		2004	2:10	A <sup>M</sup>
Ϊ,	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath	4c. Count	ty of Death		
			Casey House			Rockvil				tgomer		
ě.	Funeral		5. Social Security Number 6. Se	DM 0775	last birthday) Yrs.	If Under 1 Year Months Days	Hours M	Ain. (Month, Da	y, Year)		lace (State or try)	Foreign
A	Director		219-92-2214 Usual Residence of Decedent	39	113.			Feb. 10	, 1964	Micr	nigan	
	ow ow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City	y Limits
	Mary	to	Maryland   Montgome	ry Ge	rmanto	own					1 🗌 Yes	2 <u>X</u> No
	h the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	1h wil	aiD	11524 Dragonfire	≥ Way		20876			United			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cubai	spanic Origin? n, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	- 14. Ra	ace - Americ ack, White,		
20	hours after death with the Maryland tural; or ttems 23a or 28a-f show at Exercities must be notified at	by Fi	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊡Yes 2 ZĂNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Spec	ity: Wh	ite	
3	hour		15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ition		16b. Kind of	Business/In	dustry	
3	n n	piet	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired,	fu <i>ring</i> most of	working				
7	filed within 72 Hygiene. other then "na ent, the Medic	Completed	12	,	Offic	ce Managei			Denta		1	
<u> </u>	0 = 0 5	Be (	17. Father's Name (First, Middle, Last)					Name (First, Middle,				
<u> </u>	should the marked the marked umatic	၉	Daniel Andrew B					beth Anne				
Maryland 21215-บบรอ	and rand		19a. Informant's Name/Relationship (7			10 100		Rural Route Number				76
o)	1 and Healtl em 27 ther 1		Darryl Olson / H		Limited to the second	24 Dragoni psition (Name of matory or other place		Date	town, N			70
Baltimore,	Pages nent of int: If the		1 Burial 2 □ Cremation 3 □	Inemovariiom State		matory or other place s Cemeter	,	n. 31,	German			and
	artme artme prtant injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			2. Name and Addres		DeVol Fui			Maryra	and
ğ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic edge.		) I soul	1/1	1	O E. Deer	Park 1	Dr. Gaith	nershur		20877	
	4		23a. Part1. Enter the disease, or com- shock, of year failure. List only	plications that caused the death	h. Do not en	ter the mode of dying	g, such as care	diac or respiratory a	rrest,		Approximate Interval Betw	veen
30	Physician		Immediate Cause (Final disease or condition	Lung Cance							Onset and D	eath
	/Medical		resulting in death)	Due to (or as a conseq								
	Examiner		Sequentially list conditions,	b. Due to for as a consequence								
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseq	neuce ort							
_	al-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):							
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cai		d						III		
9	tifficat ng phy as th		TE FEMALE									
P.O. Box	th certendir	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Feta		☐Ectopic pregnancy				ate of delive	*	'ear
	e dea the at hed fo	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	leath 5[	Other (specify)						
<u>.</u>	hat the	Completed by Physician/Med	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of de	eath?
Vital Records,	w requires to been signer should be a	d by	•		,	, ,		1 🔀 ·	Yes 2□No	3 🗀 Prot	ably 4 🗆 U	Inknown
Ö	w req been shou	ete						24a. Was	an 24b	. Were auto	psy findings a	available
Re	he law e has age 2 s	E C						— autor perfo	osy ormed? 2X No	death?	mpletion of ca	luse of
ta	an: ] tifical tor, p	a)	25. Was case referred to medical				26. Place of	Death (Check only of				
<u> </u>	ysici iis cei direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Othe	er: 4 🗆 Nursin	ng Home 5 ☐ Resi	dence 6🛣0	ther (Specif	y) Hosp	ice
0	ng Pt fter tt ineral		27. Manner of Death 1 ZNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work		28d. Describe	how injury occi	urred		
<u>S</u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □ No	28f. Location (	Street and Num	abor or Pur	A Poute Mumi	hor
Division of	or At after of Direct in by	Certification:	4 Homicide determined		ome, tarm, st y)	reet, factory, office		City or To		iber or nure	ir House Marris	<i>761</i> ,
_	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 X Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the best of my kno niner: On the basis of examina	owledge, dear	th occurred at the time	ne, date and pl	lace, and due to the	cause(s) and r	nanner as s	tated.	)
	the Hin 24 the Fi	Medical	one)	and manner stated.	on and/or if			Joseph at the time,				
	To the within 2 To the complet	2	29b. Signature and title of certifier			29c. License			29d. Date sign			
7	6		Popular y	aponel		D42	432		Januar	y 2/,	2004	
	ł		30. Name and address of person who				Pond	Rockville	Moses	1004 (	20850	
	Sta	ato	Chitra Rajagopa  31. Date filed (Month, Day, Year)	32. Registrar's Signa		/		ROCKVILLE	e, mary	rand ,	20030	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 29 2	2004 Geneva	19	Spark	2					

			1- For State Registrar	e of Maryland / Depa	artment of Health ar	nd Mental Hygier	CUIII.	04213
i	Phýsic		1. Decedent's Name (First, Middle, Last) Doris Stanley O'Neal			2. Date of Death	1, 2004	3. Time of Death 5:00 A M
)	/Medi Examir		4a. Fecility Name (If not institution, give street an Vindobona Nursing	·	4b. City, Town, or Location of I Braddock Heig	Death 4	c. County of Death Frederich	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2K Usual Residence of Decedent	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min (Month, Day, Yea	9. Birthpla	ace (State or Foreign ry) .ngton, DC
	he Maryland 28a-f show offfied af	ector	10a. State 10b. County Maryland Montgomery	10c. City, Town or Lo Germantow	7 <b>n</b>			d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23s or 2	Funeral Director	10e. Street and Number 11305 Halethorpe Terra	ice	10f. Zip Code 20876		Citizen of What Count ted States	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mudical Examinar must be positived at	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Ma	res 2X No	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - America Black, White, e Specify:	
Maryland 21215-0036	d within 72 h giene. r than "natu r te Mudical	Completed	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12)  12  Colle	ge (1-4or 5+)  16a. Dece (Give life. I	dent's Usual Occupation kind of work done during most or DO NOT use retired)  987	rworking	Kind of Business/Indu	
yland	ould be filed Mental Hyg wirked othe	To Be C	17. Father's Name (First, Middle, Last) Albert Stanley		18. Mother's Elsie	Name (First, Middle, Maide Gettings	n Sumame)	
	es 1 and 2 should bot Health and Ment fitem 27 is merked rother traumatic e		19a. Informant's Name/Relationship (Type, Print, Susan Gallion/ Daughte		ng Address <i>(Street and Number o</i> Halethorpe Ter			
saitimore,	permit. Pages 1 Department of He Important: If Iten any injury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f  4 ☐ Donation 5 ☐ Other (Specify)  21. Signafure of Funeral Service ☐ Cen., e	rom State   20b. Place of Dispo cemetery, cren Parkl Memorial	sition (Name of	nuary 24, 20c. 1	ocation - City or Tow	n, State
ñ	Dep in personal perso		23a Part 1 Empr the riskase or complications t	M00689	Bethesda, Mar	ase, Inc. /5	3501 Wiscon	sin Avenue
	Physician /Medical Examiner		resulting in death)	on each line. Pneumonia B to (or as a consequence of):	or the mode of dying, such as car	diac di respiratory arrest,		Approximate Interval Between Onset and Death days
Н		dical Examiner	Cause (Disease or injury that initiated events	e to (or as a consequence of):				
.O. BOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months?	, outcome of pregnancy ve birth 2 ☐ Fetal death 3 ☐ regnant at time of death 5 ☐ nknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	ay Year
Cids, T	w requires that been signed t should be deti		Part II. Other significant conditions contributing Alzheimer's dementia	to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the	cause of death?
מו חמני	Attending Physician: The law rar death. •ctor: After this certificate has be by the funeral director, page 2 sh	Completed by				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to comp death?	y findings available letion of cause of
73 V 11	Physiciar this certif al directo	To Be		☐ Inpatient 2 ☐ ER/Outpatient	Other	Death (Check only one)  g Home 5 \(\superall Residence	6 Other (Specify)	
	or Attending Patter death. Director: After I in by the funera	atlon:	2 Accident investigation	ate of Injury 28b. Time of Injury Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how inju		
	pital or Attuurs after de sral Directo	Certification:	4 Tromicide Di	ace of Injury - At home, farm, stre uilding, etc. (Specify)		City or Town, State		
	To the Hospital within 24 hours a Volume to the Funeral I completely filled	Medical	one) and n	the best of my knowledge, death e basis of examination and/or invenancer stated.	occurred at the time, date and planting of the stigation, in my opinion, death of the stigation of the stiga	ace, and due to the cause(s ccurred at the time, date an	) and manner as state d place, and due to th	e cause(s)
	0 1 € € € € € € € € € € € € € € € € € €	~	29b. Signature and titly of certifier	i MD	29c. License number	J	te signed (Month, Da)	
			30. Name and address of person who commeter of the commeter of	My B	DUNSWICK AVE			
	Stat Registra		31. Date filed (Month, Day, Year)  JAN 28 2004	2. Registrar's Signature	Sports			

			ricuse	State of Maryla				nd Mental Hy	giene	0001					
		1	For State Registrar	olato or marytar		rtificate of			Reg. No.	2004	04	2   4			
r.	Physicia	- 3	1. Decedent's Name (First, Middle, Las	ath 2Day	2004	3. Time of 4:15									
	/Medic	al _	Annie Bell Pric			4b. City, Town, o	r Location of	Jan		County of Deeth	4.13				
	Examin		Vashington Adver		al	Takoma				ntgomer					
i i	Funeral Director		5. Social Security Number 6. Security 252-30-6721		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bi (Month, Di May 20	th ay, Year) 191	9. Birthp Cour 19 McCo	place (State of htry) rmick	r Foreign , SC			
	* J	<u> </u>	Usual Residence of Decedent  10a. State 10b. County		City, Town or La					1	0d. Inside Cit	-			
	e-fah	ctor	DC N/A	Wa	shing	ton					1 X Yes	2 🗌 No			
id 21215-0036	death with the Maryland ms 23a or 28e-f show r must be notified at	ai Dire	10e. Street and Number 32 Elmira Stre	Jnite	Citizen of What Country? ted States America										
	2 should be lied within 7.2 hours after death with the wasyan a and Menhal Hygiene. Is marked other than "natural", or Items 23a or 28e-f show reumatic evant, the Medical Examaner must be notified at	by Fur	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever in Armed Forces? 1	1	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 🛣 No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: Bla	te, etc.				
		Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	of working	16b. Kind of Business/Industry										
	id be filed w ental Hygiei ked other ti ic evant, In	To Be Co	12th 17. Father's Name (First, Middle, Last) Henry Price	, Maiden S rist	gen Self st										
	permit. Pages 1 and 2 should be Department of Health and Menta importent: If Item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  32 Elmira Street, S.W. WDC 20032												
			20a. Method of Disposition  Surial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		Place of Disp cemetery, cre rmony	osition (Name of matory or other ola Memoria	îl 28	Date 3 Jan 2004		ation - City or To dover,					
Baltii	permit. I Departm Importer any injur		21. Signature of Euneral Service Licen	reenan	1	353 H Str	eet N	Robert O.	2000:	eman Fu 2	neral	Svcs			
		8	23a. Part1. Enter the disease, or compshock, or beartfailure. List only	arrest,		Approximate Interval Bette Onset and I	ween								
E	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	10N1/6											
	Examiner		Sequentially list conditions,	b. — ASP Due to (or as a conse	10N1/4										
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
,092		cal Exa	resulting in death) Last												
687	ficate p physi as the		`												
P.O. Box	0 0	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown		2	23d. Date of delivery Month Day Year								
	iw requires that the de s been signed by the i s should be detached	d by Ph	Part II. Other significant conditions of DIARETES MED			cco use contribute to the cause of death?  212 No 3 Probably 4 Unknown									
of Vital Records,	e la has	Completed by	HYPERPENSION,	24a. Wa aut per 1 □ Yes	autopsy prior to completion of cause of performed? death?										
ital		Be Co	25. Was case referred to medical examiner?	of Death (Check only											
of V	hys this	ို	1 ☐ Yes 2 ☑ No	Hospital: Inpatient 2	esidence 6 Other (Specify) be how injury occurred										
Division (	ding F th. : After s funer	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ork? ]Yes 2□			,					
	Hospital or Attanding P 44 hours after death. Funeral Diractor: After i tely filled in by the funera	Certification:	3 Suicide 6 Could not be determined							(Street and Number or Rural Route Number, own, State)					
	e Hospital 24 hours • Funeral etely filled	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
)	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	mbru dar		05	336	7	JAN	e signed (Month	Day, Year)	2004			
2	(2)		30. Name and address of person who	completed cause of death (I	SVITE:	202, GA	THEOU	BVAC, MO	: 208	オ					
	St Regist	ate trar	31. Date filed (Month, Day, Year)  JAN 2 6 2004	32. Registrar's Sig	gnature	E)									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27, January 2004 12:05 AM Malcolm M. Patterson /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Genesis Eldercare Spa Creek Center 8. Date of Birth (Month, Day, Year) Oct. 25, 1927 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Min Hours 100 M 2□ F 76 214-26-2710 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic sysnt, the Medical Exeminar must be notified at Pasadena 1 Yes 3 No Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 80 Wiles Lane 21122 U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Assistant Harbormaster Boating 12 permit. Pages t and 2 should be file Department of Health and Mental Hy, Important: If tem 27 is marked other any injury or other traumatic svent, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie McLean Paul Chenery Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Murray/niece P.O. Box 151 Gibson Island, MD 21056 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 1/31/2004 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Land Death Premona Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a cons squence of) Examiner cause. Enter Underlying Cause (Disease or injury death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 nknown Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 **5**+10 or Attending Physician: rector. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 4 → Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No М investigation within 24 hours after death. To the Funeref Director: A thef 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32036 1/27/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goy 1- Store 2/UPD, D muto Drive Chuke, MD 2/U/9 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State JAN 3 0 2004 Registrar

		1	For State Registrar			of Man		-	rtment				lental Hy	Reg. No.	20	04	04	216	
	siciar ledica	n	1. Decedent's Name (First, Middle, Last) MARY LOU PHILLIPS								2. Date of De Month 01	Month Day Year			3. Time of 4:47				
	edica imine	-	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death											y of Death					
			402 PAMEI	-		7 4=0 //	la usa la at bist	th day)	SALI If Under		RY If Under	24 Hrs.	8. Date of Bi		COMI		lace (State of	r Foreign	
Fune Direc		1	5. Social Security Nu 218-48-85		6. Sex 1 ☐ M 2∏ F	7. Age (/	n yrs. last birt 56	Yrs.	Months		Hours	Min.	(Month, Di	ay, Year)		MARY	try)	roreign	
		-	Usual Residence of	Decedent												14	24 1-14- 01		
arylan	=	.	10a. State 10b. County 10c. City, Town or Location										11	0d. Inside Cit	•				
he Ms		600	MD 10e. Street and Num		MICO		SALISB	UKY	10f. Zip	Code				10o. Citi	zen of W	hat Coun		Λ_	
with 1	2	Funeral Director	402 PAMEI		E.				21804 USA							,			
death	T. Links	Jera	11. Marital Status	JII DICE V	12. Was De	cedent Eve	er in U.S.	13. V	1 .		spanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.				
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show	and the		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes			X∏ No Sive		Yes 2 No Specify:				Specify: W							
15-003	NEW TEN	ea DA	3 Widowed 4 Divorced Year or Dates:					16a. Decedent's Usual Occupation						16b. Ki	siness/Inc	dustry			
15 in 72	Apolloa	Completed	(Specify only highest grade completed)					(Give I	kind of wor OO NOT us	k done d	luring mos	it of work	king	9					
nd 2121 e filed within at Hygiene.	9	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER								OWN HOME								
nnd 2 be filed that Hygie	Nen (	o Re	17. Father's Name (										ame (First, Middle, Maiden Sumame) NNE WHEATLEY						
aryland should be and Mental	natic	0	CHARLES I				19h	Mailio	a Address	(Street :			al Route Numb		r Town	State Zin	Code)		
Maryland 21215-0036 nd 2 should be filed within 72 hours all the and Mental Hygiene.	trau		THOMAS A			OUSE	1		•				BURY, I						
4 2 8 E	other traumatic event, tre.	1	20a. Method of Disp	osition			20b. Place of	Dispos		ne of			Date	*			wn, State		
MOT Pages nent of int: If it	بر		1 ☐ Burial 2 ☑ 1 ☐ Donation		3 □Removal from ecify)	n State		-	-			01-2	26-2004	DELM	ίΑR,	DELA	WARE		
Baltimore, permit. Pages 1 ar Department of Hea important: If item	y in	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC.																
00 %å§	āa	1	705 EAST MAIN STREET, SALISBURY, MARYLAND 21804																
Physic			23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death disease or condition  a. Archive Interval Death Onset and Death Ons											ween Death					
/Med Exami	_		Due to (or as a consequence of):																
P	# .	ner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	to (or as a consequence of):															
60, s be executed sicien and	if-trans	Examiner	that initiated events resulting in death) L		c	o (or as a c	consequence	of):								-			
760, te be ex ysicien	₫  .	calE																	
687 ificate	9 .				u														
O. Box he death cer the attendin	ched for use	Physician/Med	in the past 12	b. Was decedent pregnant in the past 12 months?  1  Yes								/A			of deliver	,	/ear		
S, P.(	oe deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown						
cords, P w requires that been signed t	hould	eted	Museula - Diches - his								1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available								
I Rec The law	96 2	Completed	Muscular Dystrophy								autopsy performed?  1 Yes 2 No 1 Yes 2 No								
Vital Fidian: The	actor.	Be	25. Was case referred to medical 26. Place of Death (Check only one)																
Of \Physi	<u> </u>	2	1 ☐ Yes 2 🔀 27. Manner of Death			Inpatient		tpatien Time of		A	4 U N	ursing H	ome 5X Res 28d. Describe	idence how inju			y)		
OD OD oding F	fune .	ton	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of North, Day Year) 28b. Time of North, Day Year) 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No																
Divisio	d in by the	ertifica	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route City or Town, State)									il Route Num	ber,						
Division To the Hospital or Attend within 24 hours after death	letely fille	Medical Certification:	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  21 Anadical/Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											)					
To the To the To the	сошр	Me	290 Agnavire and title of certifier 29c. License number								, ,	29d. Date signed (Month, Day, Year)							
				100	me		ohrdo	9151	+ 1	)-:	530	011			12	7/0	4		
1 00			30. Name and address	1/1	who completed ca	use of dea	th (Item 23a) 1340	TType,	Print)	in.	d) <	ch =	301 Sa	lieh	10	MATE	31 81 A	14	
0 100	Stat	e.	31. Date filed (Mon	th, Day, Year)		. Registrar'	s Signature	1	1	١٥٨	<u> </u>	ت ۱۲۰۰۰	014	U C	ry	IVLD	0110		
Re	eqistra	-	J	AN 27	2004	Sener	man 1	0	100	2cks	1								

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	Certificate			200	4 04217
	Physician	1. Decedent's Name (First, Middle, La		AT ONE :		2. Date of Death Month	Day Yea	3. Time of Death
- me	/Medical	CAROLE		PALONE	4b. City, Town, or Lo	Jan cation of Death	25, 200 4c. County of Do	4 7:45 PM
	Examiner	4a Facility Name (If not institution, giv						
	Funeral	Salisbury Nursing 5. Social Security Number 6.55		ast birthday) If Under 1 \ Months D	Salisbury (ear   funder 24 Hrs lays   Hours   Min.	8. Date of Birth	Wicomic (par)	Birthplace (State or Foreign
	Director	216-38-7648	□ M 2KDF 62	Yrs.	ayo Hours Minn.	June 14,	1941 M	country) aryland
	and	Usuat Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Location				10d. Inside City Limits
	Many If she	Maryland Wicomio	o He	ebron				1 ☐ Yes 2 🔀 No
	or 28g	10e. Street and Number		10f. Zip Co		100	g. Citizen of What	Country?
	be filed within 72 hours after death with the Maryland tel Hygiene. I other than "natural; or items 23a or 28a-f show other than "natural; or items 23a or 28a-f show event, the Modical Examiner must be notified at event, the Modical Examiner must be notified at Be Completed by Funeral Director	26672 Crooked Oal			21830		USA	- vices Indian
	items items inne	11. Marital Status	12. Was Decedent Ever in U,5 Armed Forces?	S. 13. Was Decedent	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	Rican, etc.)	Black, W	merican Indian, hite, etc.
20	urs aft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1 ☐ Yes 2 💆	No Specify:		Specify:	white
2-0	be fled within 72 hou tel Hygiene. d other than "natura event, the Medical EBE Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Decedent's Usual C	Occupation done during most of working etired)	ing 16	6b. Kind of Busine	
121	Athin ne.	Elementary/Secondary (0-12)	College (1-4or 5+)				new cons cleaning	
d 2	Hygie Hygie ther ther ther ther ther ther ther the	12 17. Father's Name (First, Middle, Last,		owner/oper	18. Mother's Name			DCLVIOC
NSE lan	Mentel or stice over the or st	Tony Palone			Ruth L.	William	S	
TOWNSEND Maryland 21215-0020	She are and a she are and a she are	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (S	treet and Number or Rura	al Route Number,	City or Town, State	e, Zip Code)
	end 2 eaith e n 27 is nar tra	Michael R. Lind,			oked Oak Lan			
CAROLE timore,	ges 1 it of H if iter or oth	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	1Hemoval from State	lace of Disposition (Name emetery, crematory or other			Oc. Location - City	
CAROLE altimore,	it. Pa rtmen rtant: njury	4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer		isbury Crema		/27/04	Salisbu	
Ba	permit. Depertrimportu	Jon!	tellow					Association 1804
يتسلس		23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mode o	f dying, such as cardiac of	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	i ort		$\Lambda$	ols.		· · · k· · · ·
4	Examiner	disease or condition resulting in death)	a. Metastal	r as a consequence of):	ma of a	2007		anamour
	ne it d		h	,				
	titicate be executed g physician end as the burial-transit	Sequentially list conditions,	Due to (or	r as a consequence of):				
68760,	be es	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events routhing in death).	C					
		resulting in death) Last	Due to (or	as a consequence of):				
. Box	th cert tendin r use		d					
E	Physician: The law requires that the death cer this certificate hes been signed by the attendinated director, page 2 should be deteched for use To Be Completed by Physician/An:	Part II. Other significant conditions of	ontributing to death but not resu	itting in the underlying caus	se given in Part I.	1	_	uta to tha causa of death?
Division of Vital Records, P.O	ed by detec					1 🗆 Yas	3 _2⊡ No 3□	Probably 4 Unknown
rds	uires n sign lid be					24a. Was an		b. Were autopsy findings available prior to
2	w req s beer s shou					performe	90?	completion of cause of death?
æ	The la					1 ☐ Yes	20110	1 ☐ Yes 2 ☐ No
/ita	etor.	25. Was case referred to medical examiner?				(Check only one	)	
of V	hysic this ce al dire	1 ☐ Yes 2☐ No  27. Manner of Death	Hospital: 1 Inpatient 2			me 5 🗆 Residen 28d. Describe how		pecify)
E C	h. After tuner tion:	1 □ Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of tnjury (Month, Day Year)	tnjury M	Injury at Work? 1 ☐ Yes 2 ☐ No	Edd. Describe nor	injury boodined	
isi	Attending or death. Sctor: After by the tune	3 Suicide 6 Could not b	e co- Blass of laine. At he	me, farm, street, factory, o	ffice	28f. Location (Stre		Rural Route Number,
ă	tal or is efter an including ed in	4   Hollicide	building, etc. (Specify	"		ony or rount,	Cluitoy	
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours efter death.  To the Funeral Diractor: After this certificate hes been signed by the attending completely tilled in by the tuneral director, page 2 should be deteched for use.  Medical Certification: To Be Completed by Physician/M	29a. Certifier (Check only one) Certifying Pt 2 Medical Example (Check only one)	ysiclan: To the best of my knowninar: On the basis of examinate and manner stated.	wledge, death occurred at t ion and/or investigation, in	the time, date and place, my opinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner te and place, and o	as stated. due to the cause(s)
_	To the within To the compl	29b. Signature and title of cartifier	r/ 1	29c. L	icense number	290	d. Date signed (M	onth, Day, Year)
		1 (femils)	luffe		<b>D</b> 31853		1/26/0	4
ب / دادا	,	30. Name and address of person who.	-				1 1	
YD	X	31. Date filed (Month, Day, Year)	32. Registrar's Signal			St.Suite	,Salisbur	ry, Md.21804
3	State Registrar		2004 Seren	& Sp	all			

			1 - For State Registrar	State of M	-	•	rtment d				giene	4004	04218
	Dhusiai		1. Decedent's Name (First, Middle, Las							2. Date of De Month	ath Da	y Year	3. Time of Death
	Physici /Medio		Nicholas	Preftak	es					January	24	2004	10:30 P <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution, give				4b. City, Tov					. County of Deal	
			2113 Coleridge Dr		ge (In yrs. last bin	45-45-11	Silve If Under 1 Y	r Spr	ing der 24 Hrs.	B Date of Bir		Montgome	
	Funeral Director		5. Social Security Number 6. S 577–42–3189	5X / 7. A9		Yrs.		ays Hou		8. Date of Bir (Month, Da May 19	y, Year)		hplace (State or Foreign nuntry) Laware
			Usual Residence of Decedent		/ 4					may 15	, <u>1</u>	JZJ   DE	Laware
	yland		10a. State 10b. County		10c. City, Town	n or Loc	ation						10d. Inside City Limits
	Fa-fa	cto	Maryland Montgom	ery	Sil	lver	Sprin	g					1 ☐ Yes 2 🟋No
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ahow he Modical Exercities trivial te trollified at	Completed by Funeral Director	10e. Street and Number 2113 Coleridge Dr	ive			10f. Zip Co 20	910			•	tizen of What <i>Co</i> J <b>.S.A.</b>	ountry?
	death ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	Vas Decedent	of Hispanic	Origin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Ame	
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ If <del>Yes,</del> Give	No					Hican, etc.)		Black, Whit	
21215-0036	ours a	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:	1950		☐ Yes 2∏	No Spec	ony.			Specify: T	Mhite
5	72 h natu	ete	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>	16a.	(Give k	ent's Usual O kind of work d OO NOT use n	ccupation lone during r	nost of work	ing	16b. K	ind of Business	Industry
121	within	ig in	Elementary/Secondary (0-12)	College (1-4or	5+)		Direct				C.	ensus Bu	
9	Hygie ther int, th	ပိ	17. Father's Name (First, Middle, Last)			11 C	DITECT		other's Nam	e (First, Middle,			ireau
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural; or flems 23a or 28a-f show any joury or other traumatic avant, the Medical Examination in the profibed at once.	To Be	George Preftak	es						s Manol			
Mar	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (									ing, MD	
Baltimore,	I of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter				]	Date		ocation - City or	
Ë	tment: Pag		'4 ☐ Donation 5 ☐ Other (Specify	()	Gate o					-2004			ing, MD
Ba	Depar Impoi any ir		21. Signature of Euneral Service Licer	AQ	Q								1 Home, Inc. ig, MD 20904
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause one cause	d the death. Do r ine.	not ente	r the mode of	f dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Ana.	aplastic	Th	yroid	Cancer	:				chronic
	/Medical Examiner			Due to (or as	a consequence	of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as	a nor seguança :	of):							
	outed od ansit	Examin	Cause (Disease or injury that initiated events	c.									
oʻ	e exection and and and and and and and and and an	Exa	resulting in death) Last	Due to (or as	a consequence	of):							
8760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	dicai		d									
x 68	ertific ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of prognancy						T		
Вох	attene for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregn Other (specif					23d. Date of del Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	t time of death	30	Other (specif	у)					
Δ.	The law requires that the ste has been signed by the page 2 should be detache	y P	Part II. Other significant conditions of	ontributing to death b	out not resulting in	n the un	derlying caus	e given in Pa	art I.	23e. Did to	obacco i	use contribute to	the cause of death?
Records,	quires n sign	d by								1 🗆 1	Yes 2	XNo 3□Pr	obably 4 Unknown
8	s been si should!	Completed								24a. Was		24b. Were au	topsy findings available
Re	The lav	E								autor perfo	rmed?	death?	completion of cause of 2 No
Vital		0	25. Was case referred to medical					26. P	lace of Deat	h (Check only o		7 7 103	20110
>	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpati	ent 2 ER/Ou	itpatient	3□ DOA	Other: 4	Nursing H	ome 5 TResid	dence	6 ☐Other (Spe	cify)
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. 1	Time of njury	28c.	Injury at Work?		28d. Describe I	how inju	ry occurred	
Sio	Attending r death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М	1 Yes 2	No				
Division	after d Direct	Certification:	4 Homicide determined	288. Place of in	jury - At home, fa tc. (Specify)	rm, stre	et, factory, of	fice		28f. Location (S City or Tox	Street an vn. State	nd Number or Ru a)	iral Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exen	ysician: To the best niner: On the basis of and manner st	of examination an	e, death	occurred at ti estigation, in	he time, date my opinion,	and place, death occur	and due to the red at the time,	cause(s)	) and manner as d place, and due	stated. to the cause(s)
	ro the within. Fo the	Mec	29b. Signature and little of certifier	and mainler st			29c. Li	cense numb	er		29d. Da	te signed (Monte	h, Day, Year)
	-		> //Alm	uc.	MD.	•	D53	177			Janu	ary 26,	2004
	(U		30. Name and address of person who					to= D-	4				
	Sta	ate	John Wallma 31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	L	-		ive,	# 300, R	ockv	ille, M	ע עטטטע
	Regist	rar	JAN 28 20	U4 Alexander	was 1	J	Spor	Ks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year **Physician** Anne Brownstein Pierce an 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hebrew Home Rockville Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Yeer) March 29, 1915 Russia 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral Months Days Min 1 □ M 2 🖾 F Hours 88 498-05-2678 Director Usuel Residence of Decedent within 72 hours after death with the Marylend of Hygiene.

Other than "natural, or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is merked other than "natural", or Items 23s or 28s-f sho other traumatic event, the Medical Evandrar must be notified at 1 ☐ Yes 2K No Director Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road #598N 20852 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Š 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 end 2 should be fill of Health end Mentel H I itam 27 is merked oth å (Unavailable) (Unavailable) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 732 Clopper Road #31, Gaithersburg, MD 20878 David \_ B. \_ Pierce (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 1-27-04 Arlington, VA Depertmant Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Rapp Funeral And Cremation Service 933 Gist Avenue Silver Spring, MD 20910 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician (metastatic) /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner requires that the death certificate be executed attending physician end for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of) resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? o signed by to 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ۵ þ Records, Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? The law paga 2 : 1 Yes ZINO 1 ☐ Yes 2 ☐ No certificeta Vital Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 

Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending within 24 hours aftar daath.

To the Funeral Director: Af 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide ò Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2

State Registrar 29b. Signature end title of certifier

31. Date filed (Month, Day, Year)

onsul

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Montrose

Road

32 Registrar's Signature

0:44907

mo

CONSUELO

20ck nlle

29d. Date signed (Month, Day, Year)

			1 = State Registrar	State of Maryla			of Health of Deati			iene	2004	04220
ì	Physici	an	1. Decedent's Neme (First, Middle, Last) Constance Streif		<u> </u>				2. Date of Dear Month January	h Day	Year 2004	3. Time of Death
).	/Medic Examin	_	4a. Facility Name (If not institution, give s	street and number)			own, or Location		variuar	4c. C	2004 County of Death	
	Funeral Director		5. Social Security Number 6. Sec	7. Age (in y	rs. last birthday) 30 Yrs.	If Under 1		er 24 Hrs.	8. Date of Birth (Month, Day)	Year)		place (Stete or Foreign intry)
	laryland show	ō	Usuel Residence of Decedent  10a. State 10b. County  Maryland Montgomer		City, Town or Lo							10d. Inside City Limits
	vith the M r or 28a-f be notifi	Director	10e. Street and Number 3122 Gracefield Ro			10f. Zip (			1		en of What Cou	intry?
9	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or fleme 23s or 28s-f show event, the Medical Examinational be notified at	Funeral		12. Was Decedent Ever in Armed Forces?	1	Was Decede			ecify Yes or No- Rican, etc.)	1	Race - Amen Black, White	ican Indian, , etc.
Maryland 21215-0036	n 72 hours "natural", edical Exa	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu (Specify only highest grade)	If Yes, Give Year or Dates: 1944 (cation to completed)	16a. Dece	dent's Usual			ing		Specify: Wh.	
212	filed withir Hyglene. other then	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)		emaker					vn Home	
yland	2 should be fit and Mental H Is marked ot raumatic ever	To Be	17. Father's Name (First, Middle, Last) Baltz Streiff				Pea	arl 1		erbe	er	
, Mar	1 and 2 sh Health and Iem 27 Is m		19a. Informant's Name/Relationship (Ty William Leo Petrie	/ Husband	3122	? Grace	efield H	Road (		Silv	er Spr	ing,MD 20904
Baltimore,	Se to le		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☐ Other (Specify)	Removal from State	cemetery, cre cemetery, cre Wash Medical	matory or oth Univ Cente	versity	Januai 2004	ry 23 4	Was	ation - City or T shington	n, D.C.
Ball	permit. Pag Department Important: any injury g		Signatura Funeral Service Licen	Sada	\ Z	Name and Olumbi Olumbi O. Bo	Address of Faction Mortion 12 Address of Faction 12 Address of Fac	järy S 7 Wasl	Services nington,	, Ir	nc. 2003	7
	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	huim	er the mode	of dying, such a	nent	or respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con:  Due to (or as a con:  Due to (or as a con:	sequence of):	vasc	cular	aci	cident			
.O. Box 6	at the death certific by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pre ⊒ Other (spe				23	d. Date of deliving Month	very Day Year
٥.	quires that n signed by	by	Part II. Other significant conditions co.	ntributing to death but not	resulting in the t	underlying ca	use given in Par	t I.	TI.	acco us		the cause of death?
Division of Vital Records,		Completed							24a. Was a autops perform	med?	prior to co death?	opsy findings available ompletion of cause of
f Vit	Physician: this certific al director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA			n <i>(Check only on</i> me 5□ Reside		☐Other (Speci	ify)
sion o	ding l	Certification:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yee)	28b. Time of Injury	of 28	c. Injury at Work? 1 Tes 2		28d. Describe ho	w injury	occurred	
Σ	To the Hospital or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)				City or Town	n, State)		rai Route Number,
	To the Hospital or within 24 hours after To the Funerel Director completely filled in b	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dear sination and/or in	th occurred a nvestigation, i	t the time, date a in my opinion, de	and place, eath occurr	and due to the coed at the time, d	ause(s) a ate and p	nd manner as	stated. to the cause(s)
<b>)</b>	with	Σ	29b. Signature and title of certifier  Apulew Pull	mana,	MD	29c.	D 50				signed (Month)	
			30. Name and address of person who co	ompleted cause of death (	Item 23a) (Type, CaRA CE	Print) FIELD	ROAD	SIL				20904
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 9 20	32. Registrar's Si	onature /		als					

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	ertificate of			ene g. No. 2001	04221
	Physici		1. Decedent's Name (First, Middle Irene Par					2. Date of Death Month January	17, 2004	3. Time of Death 11:10 P. M
	/Medio Examin		4a. Facility Name (If not institution 2925 Birchtre	e Lane		Silver	Spring		4c. County of Dee Montgome	ry
8	Funeral Director		5. Social Security Number 578-40-3731	6. Sex 7. 1 □ M 2√2 F	Age (In yrs. last birthday 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) April II	Year) 1012 Co	thplace (State or Foreign buntry) W York
	Maryland 9-f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Montg		10c. City, Town or L					10d. Inside City Limits 1   Yes 2 □ No
	with the	I Director	10e. Street and Number 2925 Birchtree	Lane		10f. Zip Code 20906			g. Citizen of What Co	ountry?
36	within 72 hours after death with the Maryland ene. then "neturel", or Iteme 23a or 28e-f ehow the Madical Exertine frank by Indifficate	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Xidowed 4 Divorced	If Yes, Give	es? TNo	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner mantice untilitied at once.	Completed		nt's Education est grade completed)  College (1-4	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	king	6b. Kind of Business  Beauty Sa	
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Albert Harris	, Last)			18. Mother's Nar Rose Ro	ne (First, Middle, M		
Mary	id 2 sho ith and M 27 is ma trauma	•	19a. Informant's Name/Relations Susan Bronstei		10				City or Town, State.	
Baltimore,	Pages 1 an nent of Heal ont: If Item 2 iry or other		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (5	3 □Removal from St	20b. Place of Disp cemetery, cri	position (Name of ematory or other place	ce)	Date 2	Oc. Location - City or Olney, M	Town, State
Balti	permit. Departn imports any Inju		21. Signature of Funeral Service	. State	Lemuer I	170 ROCKV	·GOLDBERG /TI.I.E. PTK	E. ROCKVI	CHAPELS, LLE, MARY	INC. LAND 20852
	Pnysician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Ischei	mic Heart Di		ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death 75 Years
	Examiner		Sequentially list conditions.	Valvu	ras a consequence of):  lar Heart Di	isease			1	75 ₹ears
8760,	icate be executed physicien and sthe burial-transit	al Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Conge:	r as a consequence of): Stive Heart r as a consequence of):	Failure			7/	73 Years
.O. Box 687	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	nt at time of death 5	☐Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
<u>α</u>	w requires that the been signed by th should be detache	by	Part II. Other significent conditi	ions contributing to dea	th but not resulting in the	underlying cause giv	en in Part I.		acco use contribute to s 2 □ No 3 □ P	o the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform 1 ☐ Yes	prior to	utopsy findings available completion of cause of
of Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 □ In	patient 2 ER/Outpati		ner: 4 🗆 Nursing H		nce 6 Other (Spe	ocity)
<b>Division</b> c	ding h. After fune	Certification:	27. Manner of Death  1	tigation	, Day Year) Injury	M 1	yat rk? Yes 2 □No	28d. Describe how	w injury occurred eet and Number or A	ural Route Number
Divi	i Pite		4 Homicide deter	building	of Injury - At home, farm, s g, etc. (Specify)		and data and place	City or Town,	State)	
	To the Hospitel within 24 hours a  Cotherent completely filled	ledical	(Check only 2 Medica one)	I Examiner: On the bas and manne	pest of my knowledge, desist of examination and/or or stated.	investigation, in my o	pinion, death occu	irred at the time, da	te and place, and du	e to the cause(s)
)	with	Σ	29b. Signature and title of certifi	ar de	MO	29c. Licens	06 ()	29	January 1	
	,		30. Name and address of persor Alan Schneider				# 306, Si	lver Spri		
	Sta Regist		31. Date filed (Month, Day, Year JAN 2 8	r) 32. Re	gistrar's Signature	Spark		- [	<u> </u>	

				State of M	arylan		epartment of F Certificate of			ene g. No. 2 0 0		04222
			1. Decedent's Name (First, Middle, Las	")					2. Date of Death	_	Year	3. Time of Death
	Physici /Medic		Stanley Simon Pro	opper					PRINCHAL	29 200		9:28 PM
	Examir		4a Fecility Name (If not institution, give					4b. City, Town, or Lo		4c. County o		
			Calvert Manor He				day) If Under 1 Year	Rising If Under 24 Hrs.		Ceci		(Santa Francisco
	Funeral Director		5. Social Security Number 6. Se 123-09-4751 Usuel Residence of Decedent	x X M 2□F	87	ast birth Y	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 27	, 1916	New	ace (State or Foreign y) ソッカス ソッカス
	and and		10a. State 10b. County		10c. City	, Town	or Location				100	d. Inside City Limits
	Mary	ō	Maryland Ceci	Q	R	isi	ig Sun					1 ☐ Yes 2 💢 No
	r 28g	20	10e. Street and Number		1		10f. Zip Code		10	g. Citizen of W	hat Countr	ry?
	th wit	alD	1881 Telegraph R	oad			21	911		USA		
21215-0036	s 1 end 2 should be filed within 72 hours aftar deeth with the Maryland If Health end Mantel Hygiena. If Health end Mantel Hygiena. Item 27 is marked other than "natural", or items 28 or 28e-1 show other traumatic event, the Medical Examerer must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 M Yes 2 ☐ If Yes, Give Year or Dates:			13. Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 🕱 No		ecify Yes or No- Rican, etc.)		- American , White, et	
9	2 ho	Completed	15. Decedent's Edi	ication		16a. [	Decedent's Usual Occup	pation during most of work	ina 1	6b. Kind of Bus	iness/Indu	ustry
215	thin 7	npie	(Specify only highest grad	College (1-4or	5+)		Give kind of work done life. DO NOT use retire					
2	ygien rt. IT.	5		4		Un	ion Organiz	18. Mother's Name		Labor		
ğ	be fill d off	Be	17. Father's Name (First, Middle, Last)								'	
100	2 should be filed within end Mantel Hygiena. Is marked other than 'aumatic event, tre Mg	2	Harry Propper  19a. Informant's Name/Relationship (7)	una Print)		19h	Mailing Address (Stree		stheimer		State. Zio (	Code)
Baltimore, Maryland	d 2 sho th end i 7 is me traume	Î	Wulie Propoer/Gri				Persimmons					
9	Heal Heal Jem 2		20a. Method of Disposition	unuson	20b. P	lace of i	Disposition (Name of , crematory or other pla	100)		20c. Location - C		vn, State
10	ages ant of rt: if if		1 ☐ Burial 2 🗖 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				oard Funera		A. 2-1-0	4 Risin	a Sun	ı. MD
Ħ	permit. Pages 1 end 2 Depertment of Health e Important: if item 27 is any injury or other tra ance.		21. Signature of Funeral Service Licens				R. T. Foar					
ä	Deperiment of the series of th	- 1	) CT	1			111 S. Que				1911	
	Physician		23a. part1. Enter the disease or composhock, or heart failure. List only of	lications that cause one cause on each l	d the death	n. Do no	t enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	1 1	Approximate Interval Between Onset and Death
1	/Medical		Immediate Cause (Final disease or condition	ALZHO	MEN	s D	GNENTIA				1	
) 15	Fralliner		resulting in death)	a	Due to (o	rasaco	ensequence of):				1	
	p iii	ine		b							1	
,0	requiras that the daath certificate be executed seen signed by the attending physician en- hould be dateched for usa as the bunal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (o	rasaco	onsequence of):				1	
68760,	ifficate b g physic as the b	€ .	that initiated events resulting in death) Last	C	Due to (or	as a co	nsequence of):				1	
Box	v requiras that the daath certific been signed by the attending f should be dateched for usa as	Physician/M		d							1	
	daat he att	sici	Part II. Other algnificant conditions co	ntributing to death t	out not resi	ulting in	the underlying cause gi	iven in Part I.	23b. Did to	bacco use con	tribute to	the cause of death?
P.0	d by t	Phy							1 □ Ye	s 2X No	3 🗌 Prob	ably 4 ☐ Unknown
	ras th signer	Completed by							24a. Was ar	autoney	24b. Wei	re autopsy findings
Records,	requi boulc	eted							perform		avai	ilable prior to apletion of cause
ခို	S S S	шb										leath?
	ilcian: The lav certificete has rector, paga 2		OF 184					OC Place of Doct	h (Check only one			Yes 200 No
of Vital	Physician: rthis certific rral director,	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2	ER/Out	patient 3 DOA	hor	ome 5 Reside		r (Specify	)
ð	Phy erthis	n: To	27. Manner of Death	28a. Dete of Inju	ıry	28b. T	Tax tax		28d. Describe ho			
<u>.</u>	Attending r daath.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y rour,			Yes 2□No				
Division	or Atte efter da Directo	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. (Specif	ome, far y)	m, street, factory, office		28f. Location (St. City or Town	reet and Numbe , State)	r or Rural	l Route Number,
_	To the Hospital or Attending Physician: The is within 24 hours efter daath. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, paga	edicai Certification:	29a. Certifier (Check only one)  1 Certifying Phyone 2 Medical Example 19 Medical Example	yaician: To the best iner: On the basis of and manners	of examina	wledge, tion and	death occurred at the t /or investigation, in my	ime, date and place, opinion, death occur	end due to the ca red at the time, da	ause(s) and mar ate and place, e	nner as sta and due to	ated. the cause(s)
	o the o the ompl	<b>≥</b>	29b. Signature and title of certifier				29c. Licer	nse number	25	9d. Date signed	(Month, E	Day, Year)
	->-0		1 40V. 1	1			110	058419		ANUARY	30,2	004
	) 1/	)	30. Name and address of person who				Type, Print)	-				
	2+1VF	t	RODNEY DONHAM,	D.O. 188	160	EGN	APH ROAD K	ISING SUN	, MD 210	711		
		ate	31. Date filed (Month, Day, Year)	K	rar's Signa	ture						
ÿ-	Regist	rar	FEB 0 2 200	14 Salas	ار مانا	K,	Grante					
DI	IMH 16 Rev 6/1	95		•			ORIGINAL					

		1 - State Registrar				Ce	rtificate of	Death		Reg. No.	104	0422
hysici	an	Decedent's Name (First, M							2. Date of De Month	Day	Year	3. Time of Death
/Medic	cal	Anna Elisab					41. Oh. Tour	at agetion of Dec	Jan.	25	2004 y of Deeth	9:28 a.
xamir	ner	4a. Facility Name (If not instit					4b. City, Town, o		atn			J-1
manal		Anne Arundel 5. Social Security Number	Medi 6. Se	cal Cer	iter 7. Age (In yrs.	last birthday)	Annapol If Under 1 Year	If Under 24 Hr	s. 8. Date of Bir	th	9. Birthp	IQEL lece (State or Forei try)
neral ector				M 20 F	66	Yrs.	Months Days	Hours Mir		i <i>y, Year)</i> 5. 1938	Port	
		015_42_2648 Usual Residence of Deceden				h. Town out						
1	2	10a. State 10b. Co.	-			ty, Town or Lo					'	0d. Inside City Limi 1 ☐ Yes 2
in riem z/ is marked other than natural, or nams zea or cas-i snow or other traumatic event, the Michigal Examinating Installed Inciding at	Director	Maryland Anne	e Aru	indel	An	napoli	S 10f. Zip Code			10g. Citizen of	What Coun	
4	급		- D				2140	12		United		
T I	by Funeral	636 Riversid	e bri	12. Was Dece	dent Ever in U	I.S. 13.	Was Decedent of H		Specify Yes or No		ce - Americ	an Indian,
N TOP	Fu	1 Never Married 2	Marned	Armed Fo	2 No		_		rto Rican, etc.)		ack, White,	
	by	3 ☐ Widowed 4  Divo	rced	If Yes, Giv Year or Da			1 ☐ Yes 2 Ø No	Specify:		Speci	<sup>∱</sup> : whit	e
	Completed	15. Dece (Specify only hi	dent's Edi	ucation de completed)		(Give	dent's Usual Occup	durina most of w	orking	16b. Kind of I	Business/Ind	dustry
- N	ď	Elementary/Secondary (0-		College (1	-4or 5+)	life.	DO NOT use retired					
5 H		17. Father's Name (First, Mid	idia ( act)	5+_			teache		ame (First, Middle		cation	<u>1</u>
9 8 8	Be		ule, Last)					Anna P	_	, maideil Sullia	mey	
Tat Ta	ပ	Karl Backes 19a. Informant's Name/Relat	ionship (T	voe. Print)		19b Maili	ng Address (Street			er. City or Town	State Zio	Code)
trau			,	,,,,,,			Greenbria					-
important: if item 27 any Injury or other tra		Nils Reuter/ 20a. Method of Disposition	son_		20b. I	Place of Dispo	sition (Name of		Date	20c. Location		wn, Stete
7 0		1 ☐ Burial 2 ☐ Cremat 1 ☐ Donation 5 ☐ Other			state	,	natory or other place		1 21 04	7.1	and a	777
Injur		21. Signature of Funeral Sen			Me		itan Cren 2. Name and Addre		1-31-04 ohn M. Ta			
any ir		1 91.210	H.	Kema	mush	1	47 Duke o					
dical niner	n al	disease or condition resulting in death)	ſ	b	or as a consec	quence on:	embo	ICT AN				
burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	1	c	or as a consec							
burial-transit	cal	that initiated events	1	c	or as a consec	quence of): ancy al death 3[	Ectopic pregnancy				ate of delive	ry Day Year
burial-transit	Physician/Medical	Cause (Disease or injury that infiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnan in the past 12 months?  1 □ Yes 2 □ No		c	come of pregn	ancy al death 3 [ Jeath 5 [	Other (specify)		23e. Did t	obacco use cor	onth	Day Year e cause of death?
been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No		c	come of pregn	ancy al death 3 [ Jeath 5 [	Other (specify)		24a. Was autopendo	obacco use cor Yes 2 No an 24b. promed?	onth  ttribute to th	Day Year  e cause of death?  ably 4 Unknown  by findings availat  npletion of cause of
been signed by the attending physicien and should be detached for use as the burial-transit	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant con	pill	c	come of pregn	ancy al death 3 [ Jeath 5 [	Other (specify)	en in Part I.	24a. Was autopendo	obacco use cor Yes 2 No an 24b. pry ymmed?	onth  atribute to th  The second of the seco	Day Year  e cause of death?  ably 4 Unknown  by findings availat  npletion of cause of
been signed by the attending physicien and should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1	pill com	d	come of pregninh 2 Feta ant at time of cown	ancy al death 3 [ death 5 [ death 5 [ death 5 [ death 5 ] ]	other (specify)	en in Part I.  26. Place of Deer: 4 \( \text{Nursing} \)	24a. Was autoperfo	obacco use con Yes 2 No an psy ormed? 2 Ne cone) dence 6 Ot	onth  all Prob  Were autoprior to cordeath?  1 Yes  her (Specify	Day Year e cause of death? ably 4 Unknov sey findings availat inpletion of cause of
been signed by the attending physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1   Yes   2   No 9   Unknown  Part II. Other significant con examiner   1   Yes   2   No   25. Was case referred to me examiner   1   Yes   2   No   27. Manner of Death   1   Natural   5   Period   2   Accident   3   Suigide   6   Cot	pill dical	Due to (d	come of pregninh 2 Feta ant at time of cown sath but not result to the companient 2 for injury h, Day Year)	ancy al death 3 [Jeath 5 [Jeat	nderlying cause give the control of	en in Part I.  26. Place of Deer: 4 \( \text{Nursing} \)	24a. Was autoperformed to the control of the contro	obacco use con Yes 2 No an psy ormed? 2 Ne cone) dence 6 Ot how injury occu	onth  3 Prob  Were autoprior to cor death? 1 Yes  her (Specify	Day Year e cause of death? ably 4 Unknov sey findings availate in pletion of cause of 20 No
been signed by the attending physicien and should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1   Yes   2   No 9   Unknown  Part II. Other significant con examiner   1   Yes   2   No   25. Was case referred to me examiner   1   Yes   2   No   27. Manner of Death   Natural   2   Accident   3   Suidde   6   Cd   de    29a. Certifier   Cert	ditions co	Due to ( d	come of pregninh 2   Feta ant at time of cown patient 2   Tof Injury h, Day Year)  of Injury - At h ng, etc. (Special best of my kni	ancy al death 3 [ death 5 ] ] ] ] ] ] The content of the	other (specify)	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Was auto peric 1 Yes eath (Check only of 28d. Describe 28f. Location (City or Total)	obacco use cor Yes 2 No an psy Drmed? 24b. Done) dence 6 Ot how injury occu  Street and Num wm. State)  cause(s) and m	onth  attribute to th  The problem of the prior to cordeath?  The problem of the prior to the prior to cordeath?  The problem of the prior to the prior the	Day Year  e cause of death?  ably 4 Unknow  say findings availab  inpletion of cause of  2 No  // Route Number,  ated.
been signed by the attending physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant con 12 months? 25. Was case referred to me examiner 1   Yes 2   No 27. Manner of Death   Natural 5   Period   Natural 5   Per	additions co	Due to ( d	come of pregninth 2   Feta ant at time of cown  path but not result in the compatient 2    of Injury h, Day Year)  of Injury - At h ng, etc. (Speci	ancy al death 3 [ death 5 ] ] ] ] ] ] The content of the	nderlying cause given to a control of the control o	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Was auto peric 1 Yes eath (Check only of 28d. Describe 28f. Location (City or Total)	obacco use cor Yes 2 No an psy Drmed? 24b. Done) dence 6 Ot how injury occu  Street and Num wm. State)  cause(s) and m	onth  all prob  Were autory prior to cordeath?  1 Yes  her (Specify rired)  ber or Rura.  anner as st. and due to	Day Year  e cause of death?  ably 4 Unknow  bosy findings availab  ppletion of cause of  2 No  //  // Route Number,  ated. the cause(s)
burial-transit	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant con 1   Yes 2   No 27. Manner of Death 1   Natural 5   Pe 2   Accident 3   Suicide 6   Code 4   Homicide   Accident (Check only one) 1   Cent (Check only one) 1	additions co	Due to ( d	come of pregninth 2   Feta ant at time of cown  path but not result in the compatient 2    of Injury h, Day Year)  of Injury - At h ng, etc. (Speci	ancy al death 3 [ death 5 ] ] ] ] ] ] The content of the	nderlying cause given to 3 DOA Other (Specify)	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Was auto peric 1 Yes eath (Check only of 28d. Describe 28f. Location (City or Total)	obacco use cor Yes 2 No an psy primed? 2 No dence 6 Ot how injury occu  Street and Num wm. State)  cause(s) and m date and place	onth  all prob  Were autory prior to cordeath?  1 Yes  her (Specify rired)  ber or Rura.  anner as st. and due to	Day Year  e cause of death?  ably 4 Unknow  bosy findings availab  piletion of cause of  2 No  //  // Route Number,  ated. the cause(s)
been signed by the attending physicien and should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant con 1   Yes 2   No 27. Manner of Death 1   Natural 5   Pe 2   Accident 3   Suicide 6   Code 4   Homicide   Accident (Check only one) 1   Cent (Check only one) 1	dical dical dical ending restigation and not be termined tifying Phylical Exam	Due to (d	come of pregninh 2 Feta ant at time of cown sath but not result to finjury and finjury at hing, etc. (Special Special	ancy al death 3 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 [Jeath 5 Jeath nderlying cause given to a Signature of the Company	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Was auto peric 1 Yes eath (Check only of 28d. Describe 28f. Location (City or Total)	obacco use cor Yes 2 No an psy primed? 2 No dence 6 Ot how injury occu  Street and Num wm. State)  cause(s) and m date and place	onth  all prob  Were autory prior to cordeath?  1 Yes  her (Specify rired)  ber or Rura.  anner as st. and due to	Day Year  e cause of death?  ably 4 Unknow  posy findings availab  npletion of cause of  2 No  //  // Route Number,  ated. the cause(s)	

			1 - For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H tificate of L	ealth an D <i>eath</i>	nd Mental Hy	giene 2 (	0	04224
	Physici /Medic		1. Decedent's Name (First, Middle, L Mortimer	ast)	]	Rosenha	ft		2. Date of De Month Janua:	Day	Year 2004	3. Time of Death 2:45 AM
leg .	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of D	Death		y of Death	
		- 4	3310 N. Leisur				Silve If Under 1 Year	r Spri			ontgo	
	Funeral Director		5. Social Security Number 6. 095-18-1235	Sex 1M∑M 2□F	7. Age (in yrs	. last birthday) Yrs.	Months Days		Min. 8. Date of Bir (Month, Da Sept. 2	n y, Year) 7 1920		place (State or Foreign ntry) York
	D		Usual Residence of Decedent						верс. 2	.7,1920	IVEW	TOTK
	arylan ahow	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	10d. Inside City Limits
	he Ma Ba-f	Director	Maryland Montgo	nery			Silver	Sprin	g			1 ☐ Yes 2 No
	with tage of 2	Dir	10e. Street and Number	11 -		201	10f. Zip Code			10g. Citizen of		
	beath ns 23	Funeral	3310 N. Leisure	12. Was Dec	edent Ever in I			0906 spanic Origin	? (Specify Yes or No	United	d Sta	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If tiem 27 is marked other than "natural", or tiems 23a or 28a-f ahow minportant: If tiem 27 is marked other than "natural", or tiems 23a or 28a-f ahow any injury or other traumatic event, In a Madical Examinar must be notified at once.	by Fun	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 Tes If Yes, G Year or I	2 Mo ive		f Yes, specify Cubai I □ Yes 2 🔯 No		? (Specify Yes or No Puerto Rican, etc.)	Speci	ick, White, fy:	etc. White
5	2 hou		15. Decedent's	Education		16a. Deced	lent's Usual Occupa	ition	· · · · · · · ·	16b. Kind of E	Business/In	dustry
2	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)		(1-4or 5+)	life. L	kind of work done d OO NOT use retired,	uring most of )	working			
7	led wi			4		Elect:	ronic Tes					vernment
2	d be fi	o Be	17. Father's Name (First, Middle, Las Harry	Rosenha	ft			Kate	Name (First, Middle, F11)	<i>Maiden Sumai</i> 1rman	ne)	
<u></u>	should nd Me mark math	Ĕ	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a		or Rural Route Number		, State, Zip	Code)
Ž	alth a		Shirley K. Rosen	haft /	Wife							20906 Spring, MD
กั	of He of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	Compunit from	1	Place of Dispos	sition (Name of natory or other place	- 1	Date nuary 28,	20c. Location		
altallo	Pag- ment ant: h	2000000	*4 □Donation 5 □Other (Spec			esapeak	e Cremato		2004	Belt:	sville	e, MD
Da	permit. Depart import any inj	Ī	21. Signature of Funeral Service Lice	ensee 2. Zha	2	Ra 93	Name and Addres app Funer 33 Gist A	al & C	remation S ilver Spri	Services Ing, MD		910
U	大変 で		236. Part1 Enter the disease, or co shock, or heart failure. List on	mplications that	caused the dea							Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	00	1 .		-smell c					Onset and Death  Z months
V	/Medical Examiner		resulting in death)		(or as a conse							
		-	Sequentially list conditions, if any, leading to immediate	b	for as a conse	quence on:						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		(	7						
ົ	exectan and rial-tra	Еха	resulting in death) Last	c. Due to	(or as a conse	quence of):						
0070	cate be executed physician and the burial-transit	dlcal		d								
0	eath certificate be executed attending physician and for use as the burial-transit	40 t	IF FEMALE:			Ti .				-		- 11E
700	attend attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	tcome of pregri birth 2 Fet	el death 3	Ectopic pregnancy				ite of delive	ery Day Year
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preg 9□ Unkr	nant at time of lown	death 5□	Other (specify)					•
	that hed by deta	by Ph	Part II. Other significant conditions	contributing to	leath but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
, ב	quires nn sigr uld be		hypercalcenia						1 □ Y	es 2□No	3 Prob	ably 4 Unknown
2	aw re	plet	hypertension						24a. Was		Were auto	psy findings available
	The ate ha	Completed	14						— autop perfo	med?	death?	npletion of cause of
בם	cian: ertific ector,	Be (	25. Was case referred to medical examiner?	Non-Sel.					Death (Check only o	ne)		
5	Physi this c al dire	2	1 Yes 2 No			ER/Outpatient		4 U Nursin	ng Home 5 Mesic			"
5	ding h. After funer	tion	1 ☐Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \(\sum Y\)	at ? ′es 2 □ No	28d. Describe h	ow injury occur	reg	
2	Aften r deat sctor: by the	Certification;	3 Suicide 6 Could not	be 28e. Place	e of Injury - At h	nome, farm, stre	eet, factory, office		28f. Location (S	treet and Numb	er or Rura	l Route Number,
5	s afte	Sert	4 Homicide	build	ling, etc. (Speci	ity)			City or Tow	m, State)		
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier 1 Certifying F (Check only one) 2 Medicei Exa	i <b>miner:</b> On the t	e best of my kn pasis of examin oner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and pl inion, death o	lace, and due to the occurred at the time, o	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	vithin To th compl	Me	29b. Signature and title of certifier		7		29c. License	number		29d. Date signe	d (Month, L	Jay, Year)
	8		Find N	Sun	ella	1.6	035	5996		01.2	8-04	4
			30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type, f	Print)					
			Linda M Burre		2730	Univers	ity Blud.	# 400.	Wheeten	.MD	2090	2
	Sta Registr	_	31. Date filed (Month, Day, Year)	1114	Registrar's Sign	B	Someth	/				

		•	for State Registrar	State of M	larylar		artment of F		ınd Me		iene <sub>99. No.</sub> 200	4 04225
	Physici	an	1. Decedent's Name (First, Middle,						~	Date of Deat Month	Day Ya	3. Time of Death
	/Medic		ANDREI		ENBEI	RG	45 05 7			ANUARY	29, 2004	
	Examin	er	4a. Facility Name (If not institution, 10500 ROCKVILLE		,		4b. City, Town, o		i Death		4c. County of D	
	Funeral			5. Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth (Month, Day,		
	Director		215-80-3842	1⊠M 2□F	76	Yrs.	Months Days	Hours	0.7	7/31/19	27 CZ	Birthplace (State or Foreign Country) ECHOSLOVAKIA
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Mary I sh	ţo	MARYLAND MONTGO	MERY	ROCI	KVILLE						1 X Yes 2 □ No
	death with the Maryland ims 23a or 28a-f show r must be notified at	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen of What	: Country?
	ath w	rai	10500 ROCKVILLE				20852				.S.A.	
	itams Irecm	Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marrie	12. Was Deceden Armed Forces d 1 ☐ Yes 2 🕅	?	.S. 13.	Was Decedent of I If Yes, specify Cub	dispanic Orig an, Mexican,	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		American Indian, Vhite, etc.
936	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2⊠ No	Specify:			Specify:	WHITE
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup	during most	of working		16b. Kind of Busine	ess/Industry
121	within ane. than '	idm	Elementary/Secondary (0-12)	College (1-4or	5+)	DELIM.	DO NOT use retire A N	d) -		F	OOD SERVI	CE
d 2	filed Hygie Hygie other III	ဝိ	17. Father's Name (First, Middle, La	ast)		DELIE	AIN	18. Mother	r's Name (F		Maiden Sumame)	.00
<u>la</u> n	Aental Aental rkad c	To Be	HERMAN	ROSI	ENBER	G		ETHEL	KLEI	N		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury og other traumatic event, it is Micciest Examiner mast be notified at ances.		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	ng Address (Street	and Number	r or Rural P	loute Number,	City or Town, Stat	e, Zip Code)
≥,	and sealth m 27		YURI ROSENBERG/	SON	20h [		AVON DR.	, BETH	ESDA,			
Jore	H in its	l ŝ	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3		.   "	cemetery, crei	natory or other pla				20c. Location - City	
Baltimore,	ortant:	i	* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		GAR		THE RESIDENCE OF THE PARTY OF T					G, MARYLAND
Ba	Depa Depa tmpo any ir		1 amanda	Ludeu	Ka	EI 10	OWARD SAC 91 ROCKV	EL FUN	NERAL IKE,	DIRECT ROCKVI	TION, INC LLE, MD 2	0852
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cause nly one cause on each	d the deet	h. Do not ent	er the mode of dyi	ng, such as c	cardiac or r	espiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. RESPIRA	FORY	FAILUR	E					Onset and Death 24 HOURS
	/Medical Examiner		resulting in death)	Due to (or a		uence of):						1 YEAR
		er	Sequentially list conditions, if any, leading to immediate	b. LYMPHOM. Due to (or a		uence of):						I IEAN
	uted id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<sub>c</sub> PANCYTOF	ENIA							
Ó,	ate be axecuted hysician and the burial-transit	EX	resulting in death) Last	Due to (or a	s a conseq	uence of):						
8760,	icate be axecuted physician and s the burial-transit	dical		d								
9 X 6	death cartific e attending p id for usa as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date of	delivery
. Box	death e atter	Iclar	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnanc Other (specify) _	y 			Month	Day Year
P.O.	the y th	hys	9 ☐ Unknown ¯	9□ Unknown								
Division of Vital Records, I	law requiras that as baen signed b 2 should be date	ğ	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause gr	ven in Part I.				e to the cause of death?  Probably 4 Unknown
ecc	elawre hasba je 2sh	Completed								24a. Was ar autops	v prior	autopsy findings available to completion of cause of
<u>=</u>	Th ata pag									perform 1 ∐ Yes 2		1? ∕es 2□ No
Vita	Phyalcian: Tribis certifical	) Be	25. Was case referred to medical examiner?  1 1 Yes 2 1 No	Hospital:	in 0 🗆	ED/Outpation	. all post lot	A.F.		Check only one		Na = 16.1
ō		<u>ان</u> 1	27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		ER/Outpatier 28b. Time o	I 3L DOA	4 🗆 1901			nce 6 Other (S w injury occurred	респу)
ion	Attanding Phy r death. ector: After thi by the funeral o	atio	1 Natural 5 Pending 2 Accident investiga	tion	ay rear)	Injury		Yes 2 □ N	40			
ivis	or Attandation death	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		njury - At h tc. <i>(Specit</i>	ome, farm, str	eet, factory, office		28f	Location (Str City or Town		Rural Route Number,
۵	e Hospital 24 hours a 8 Funaral [ letely filled		29a. Certifier 1   ☐ Certifying	Physician: To the bes	t of my kno	wiedge, deati	occurred at the ti	me, date and	d place, and	due to the ca	use(s) and manner	r as stated.
	To the Hospital or At within 24 hours after of To tha Funaral Direct completely filled in by	edical		kaminer: On the basis and manner s	of examina					at the time, da	ate and place, and	due to the cause(s)
	To the within 2. To the Complet	Σ	29b. Signature and title of certifier	0	1	00	29c. Licens	se number	/ -	- 4	d. Date signed (M	
	10		J. Jela	man	dakir (1)	1 ()	Print)	041	6	34	1-29	-2004
			30. Name and address of person w IRENE FELDMAN,					, BETH	HESDA	, MARYI	AND 2081	4
**	Sta Registr		31. Date filed (Month, Day, Year)  JAN 30	32. Regis	trar's Signa		Spark					
25.24	negisti	ш	OUIL O O	-OUT /ey		/-	//					

			For State Ragistrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of I	lealth and <b>I</b> <i>Death</i>		jiene2 () ( lag. No.	14 04226	
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	th	3. Time of Death	
	/Medie	al	LESLIE ANN 4a. Facility Name (If not institution, give			4h O'h T	r Location of Death	Januar	4 24,2	004 1629 PM	
	Examir	er	Shady Grove Ad		Hospital		kville	1	,		
	Funeral Director		5. Social Security Number 6. Se 219-74-0255	7. Age	(In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 6,	Year) 1959	3. Time of Death 1629 PM of Death 17GOMERY  9. Birthplace (State or Foreign Country) Maryland  10d. Inside City Limits 120 Yes 2 No  That Country?  6. A.  9. American Indian, K, White, etc. Black siness/Industry  6. A.  9. State, Zifffye) 20876 Germantown City or Town, State er Spring, MD AL HOME, P.A. MD 20850  Approximate Interval Between Onset and Death Note of detivery The Day Year  Dute to the cause of death? 3 Probably 4 Unknown  Pere autopsy findings available for to completion of cause of eath? The Country of the Day Year  Of (Specify)  d  To rall Route Number,  Indian Stated.  (Month, Day, Year)	
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d toside City Limits	
	Maryl Fred	tor	MD Montg	omery		ermanto	wn				
	ath with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 19513 Gunner	s Branch	Rd., #L	10f. Zip Code	0876	1	0g. Citizen of Wh		
980	after de	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4X Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of H if Yes, specify Cuba 1 ☐ Yes <b>2</b> ☐No	lispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black, Specify:	White, etc.	
Maryland 21215-0036	within 72 hours ene. than *natural', be Wedical Exc	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation de <i>completed)</i> Coltege (1-4or 5-	(Give	dent's Usual Occup kind of work done o DO NOT use retired inistra	during most of won d)		16b. Kind of Busi		
d 2	e filed within al Hygiene. I other than '	Be Co	17. Father's Name (First, Middle, Last)		Adin	IIIISCIA		ne (First, Middle, I			
ylar	2 should be f and Mental H Is marked of reumatic eve	To B	Charles H. Wi	lson, Sr				lia M.			
Mar	s 1 and 2 should f Health and Mer itam 27 is marke other treumatic		19a. Informant's Name/Relationship (7) Danielle Redma	,							
<u>o</u>	s 1 an f Heal itam 2 other		20a. Method of Disposition		20b. Place of Dispo		i i	-			
Baltimore,	Pages ment of ant: If i		tv Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	0 0	Gate of			/31/04	Silve	r Spring,MD	
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre once.		21. Signature of Europeal Service Licent	· Dro	1. 1.1.1	Name and Address				THE STATE OF THE S	
			23a. Part1. Enter the disease, or comp shock, or heart failule. List only of	lications that caused t ne cause on each line	the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	u	consequence of):	er ace	ident			1	
	Examiner		Soquentially list conditions	h							
1.2	pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (bras a	eonsaquenes of).		-				
Ć,	rificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);						
68760,	ste be nysicia he buri	edical		d			_				
.O. Box 68	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 2 No 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		
Д.	that the ed by detacl	/ Phy	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribi	ute to the cause of death?	
ords	w requires been sign should be	ted by	hypertension			-					
of Vital Records,	: The law r cate has be page 2 sh	Completed						24a. Was ar autops perform 1 Yes 2	y prio	r to completion of cause of the	
Vita	Physician: this certificatal director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	3 C E D C	Othe		h (Check only one			
J of	g Phy ter this neral d	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day	t 2 ER/Outpatien  28b. Time of  Year) Injury	28c. Injury Work	4 U Nursing Ho	ome 5 Reside 28d. Describe ho			
Division	tendin leath. tor: Af the fur	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Y	Yes 2□No				
Divi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	building, etc.				City or Town	, State)		
	e Hosp 24 hou e Funs letely fil	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or invest.	occurred at the tim estigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mann- ite and place, and	er as stated. I due to the cause(s)	
	To th withir To th comp	₩ We	29b. Signature and title of certifier	4		29c. License					
	3			Jellis	try MC	D5	9738	J	enuer	1 24, 2004	
			30. Name and a fress of person who or Alicia Mistry		ath (Item 23a) (Type, I Medica	Print) Cent	er Priv	e Rax	wille.	MD 20850	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Sporks					

			For		land / Depa	artmen	t of Health and	-	ene .	
			1 = State Registrar		Cei	rtificat	e of Death	Reg	. No. 2001	+ 04227
	Dhusisi		1. Decedent's Name (First, Middle, Las	)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici: /Medic		Martha Lo	uise Chance	llor Rat	7		January		
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location of Deat		4c. County of D	eath
				y Boulevard	um laat himbaaul	If I Inde	Bethesda 1 Year   If Under 24 Hrs			tgomery
	Funeral		5. Social Security Number 6. Se	IM 2ĬXÍF	yrs. last birthday) Yrs.	Months			Year) 9.1	Birthplace (State or Foreign Country) Louisiana
1.	Director		435-16-2755 Usual Residence of Decedent	84				March 31	, 1919	Louisiana
	/land		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar	ţŏ	Maryland Montgo	mery			Bethesda			1 ☐ Yes 2 X No
	h the	Directo	10e. Street and Number			10f. Zip	Code	10	g. Citizen of What	Country?
	filed within 72 hours after death with the Maryland Hydiona. Ither than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at		5731 Brad1	ey Boulevar	d		20814		Unit	ed States
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dece If Yes, spe	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 🗆 Yes			Specify:	
2-0036	ural	d by	3 Widowed 4 Divorced	Year or Dates:	162 Door	dont's Llau	al Occupation	14	6b. Kind of Busine	White
5	n 72	lete	15. Decedent's Ed (Specify only highest grades)	de completed)	(Give	kind of wo	rk done during most of wo		oo. Kind of busine	as a modelity
12	withi ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 1		Ŧ	lomemaker		Owr	n Home
<u>0</u>	Hyg other	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma	aiden Sumame)	
a	lid be lentai ked ic ev	To B	Kennetl	. Watt Chanc	ellor			Jeanet	te Dodge	2
Maryland 2121	should be made in made	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address	(Street and Number or R	ural Route Number,	City or Town, Stat	e, Zip Code)
Σ	and 2 alith a	,	Robert H. Ratclif				p Lane Bethe	sda, Mary	land 208	14
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Hygie		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Ob. Place of Dispo Arlingt	matory or o	me of other place) Fol	Date 20	Oc. Location - City	or Town, State
altimore,	Out in the Page		'4 □ Donation 5 □ Other (Specify		Nationa	.L Cen	etery 5.	2004	Arlingto:	n, Virginia
alt	aparti aport ny inj		21. Signature of Funeral Service Licen	900	22 B	2. Name ar	nd Address of Facility Ro	bert A. P	umphrey 7557 Wis	Funeral Home/ consin Avenue
<u> </u>	<u> </u>		X kego )/	leghert Mi	00335   B	ethes	da. Marvland	L 20814-35	01	
			23a. Part1. Enter the disease or comp shock, or heart failure. List only	lizations that caused the one cause on each line.	death. Do not en	ter the mod	le of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Primary H	Peritonea	al Ca	rcinoma			4 Months
П	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):					
75		-	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due to (ur as a cor	nagudijes vij.					
	red	n in	Cause (Disease or injury		,					
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
<u> </u>	icate be ex physician s the buria	cail		d						
89	death certificate e attending physical for use as the	ledi								
Box	h cer endir r use	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		⊒Ectopic p	regnancy		23d. Date of	
	ie deat the att hed for	sicis	in the past 12 months? 1 ☐ Yes 2 🔯 No	4 ☐ Pregnant at time 9 ☐ Unknown		Other (s			Month	Day Year
P. O.	by tac	Physician/Medi	9 Unknown		A Was to the			22a Did taha	and the contribut	e to the cause of death?
	res tha signed be de	by	Part II. Other significant conditions of	ntributing to death but no	ot resulting in the L	ingeriying (	ause given in Part I.			Probably 4 Unknown
orc	w requires to been signer should be	Completed								<u> </u>
Sec	e law has b	npl m						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of
E F	T each							1 Yes 2		res 2□ No
Vital Records,	Physician: The this certificate hiral director, page	Be	25. Was case referred to medical examiner?	Hospital:	-0	-0-	Othor	ath (Check only one		
ō	Phys r this ral dia	. To	1 Yes 2 No 27, Manner of Death	1 Inpatient	2 ER/Outpatie		28c. Injury at	Home 5 X Residen		pecity)
O	ding th. : Afte	ţ	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	М	Work? 1 ☐ Yes 2 ☐ No			
Division	Attending it death.  ctor: After by the fune	ifica	3 Suicide 6 Could not be 4 Homicide determined	286. Place of Injuly	At home, farm, st	reet, factor	y, office			Rural Route Number,
ā	s after si Dire	Certification;	4 - Homeda	building, etc. (S	респу			City or Town,	J.a.toj	
	Hospital 24 hours a Funeral letely filled						at the time, date and place, in my opinion, death occ			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	one)	and manner stated.	nation and/or in					
	To the Within 2 To the complet	Σ	29b. Sign ture and title of certifier	16 1	0. 1.	29	c. License number	29	d. Date signed (M	onth, Day, Year)
7*	5		Mary 18	Arnun	in M	9	р37236		January 2	26, 2004
			30. Name and address of person who							1 00017
			Carolyn B. Hendri 31. Date filed (Month, Day, Year)	32 Banistrar's S	Signature #			Bethesda,	Maryland	1 2081/
-10	Sta Regist		IAN 2.8 20	104 Bener	as by	140	acket			

		-	For State Registrar	State of	Maryland /	-	artment <i>tificate</i>			and Me		iene <sub>eg. No.</sub> 2	2004	04	228
			Decedent's Name (First, Middle, Last)	)						2	2. Date of Dea	th	М	3. Time o	f Death
	Physici		RUSSI	ELL J. F	RICHARDSC	N				J.	Month ANUARY	Day 31	2004	6:45	РМ
7	/Medic Examin	_	4a. Facility Name (If not institution, give	street and numb	per)		4b. City, 7	Town, or	Location o	of Death		4c. Co	unty of Death		
			HARFORD MEMORIAL H	HOSPITAI			H	IAVRE	E DE	GRACE		1	HARFORI	)	
	Funeral		5. Social Security Number 6. Sec		. Age (In yrs. last i		If Under Months	1 Year Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day	Year)	9. Birth	place (State ontry)	or Foreign
н	Director		217-20-0302	<b>M</b> 2□F	76	Yrs.	WORKING	Days	710010			1, 19:		nsylva	ania
	pu 💌	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside C	'ity Limits
	sho	5	Maryland Hari	Ford	100. 0.19, 10	01 20	oution.	TT							2 X No
	28a-f	Director	10e, Street and Number	LOIG			10f. Zip		re d	e Gra		On Citizer	n of What Cou		
	a or		817 Juniata Stre	oct			101. 2.10		078		'	og. Onizer		•	
	eath	Funeral	11. Marital Status		ent Ever in U.S.	13. \	Vas Deced			gin? (Speci	ifv Yes or No-	14.	USA Race - Ameri		
10	ter d	Ę	1 ☑ Never Married 2 ☐ Married	Armed Ford	es?	1			n, Mexicar	i, Puerto Ri	ify Yes or No- ican, etc.)		Black, White	etc.	
936	urs a	<u>a</u>	3 Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Dat	es:1945-47	7	1□Yes 2	2(X <sub>N</sub> o	Specify:			Sp	ecity: Bla	ck	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or tlems 23e or 28e-f ehow he Madical Expiritive rouel by multified at	Completed	15. Decedent's Edu (Specify only highest grad		16		ient's Usua			t of working	,	16b. Kind	of Business/Ir	ndustry	
21	thin 7	pie	Elementary/Secondary (0-12)	College (1-4		life.	DO NOT us	e retired,	)						
	ed with /giene.	Con	11		Ai	r Co	nditi	oner			t Oper.		Govern	ment	
nd	be fit d oth	Be	17. Father's Name (First, Middle, Last)								First, Middle,		mame)		
<u>y</u>	Men Men Marke Marke	ဥ	Ernest Richardson								Christy				
Maryland	12 should be filed w n and Mental Hygie is marked other ti raumatic event, In		19a. Informant's Name/Relationship (Ty				0011				Route Number			p Code)	
	1 and 2 Health tem 27 i		Cleo Cole / friend 20a. Method of Disposition	1	20b. Place				Stree	et, Ab	oerdeer		21001 tion - City or T	own State	
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or Items 23a or 28a-f show int: If item 27 is marked other than "natural; or Items 23a or 28a-f show into other traumatic event, the Madical Exprinted round by notified at		1 N Burial 2 ☐ Cremation 3 ☐ F		tate ceme	tery, crer	natory or of	ther place	1						
ţ	t. Partmer		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>		Union		. Name and				/04	Abe	rdeen,	Maryl	and_
Bal	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Pureral Service Licens	cott.		22	Lisa	Sco	tt Fi	ineral	l Home,	P.A.			
			23a. Part1. Enter the disease, or compl	lications that car	used the deeth. D	o not ent	552 er the mode	Lewi	S Sta	ceet,	Havre	de Gr	race, M	D 2107	7 <del>8</del>
			shock, or heart failure. List only o Immediate Cause (Final	ne cause on ea	ch line.									Onset and	tween
À	Physician /Medical		disease or condition resulting in death)	a. Dua to /o	r as a consequence			allu	ire				+		
	Examiner			Due to (o	as a consequent	Je OI).									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (o	r as a consequenc	ce of):									
76	executed in and ial-transit	Examiner	Cause (Disease or injury that initiated events	c											
o,	an an rial-tr	EX	resulting in death) Last	Due to (o	r as a consequenc	ce of):									
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical		d											
9	ndiffice ng pt	Med	IF FEMALE:												
Вох	ith ce tendi	an/	23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 □ Fetal dea		Ectopic pro	egnancy				23d	I. Date of delive Month	•	Year
. E	requires that the death certific een signed by the attending p nould be detached for use as	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of death wn	5	Other (sp	ecify)						,	
P.O.	w requires that the de been signed by the s should be detached	Æ	Part II, Other significant conditions co	ntributing to dea	ath but not resulting	a in the u	nderlying c	ause dive	en in Part I		23e. Did to	bacco use	contribute to	the cause of	death?
ds,	signe	1 by	Lung Cancer			<b>3</b>						es 2 N			Unknown
Ö	requ	etec	-								24a. Was a		Ab More out	annu findings	avadeble
3ec	ne law has b je 2 sl	mp		·							autop	sy med?	24b. Were autoprior to condeath?	ompletion of o	cause of
<u>a</u>	n: The licate har, page											2 No	1 🗆 Yes	2□ No	
V:E	ding Physician: The lav h. After this certificate has tuneral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	aCICD	(0. 11		Othe	ar .		(Check only or		704 (0	4.1	
of	Phys rahis	.: To	1 Yes 2 No	28a. Date of	Injury 281	Outpatier  b. Time o		8c. Injury	/ at		e 5 Resid			ry)	
O	ding th: Afte tune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		, Day Year)	Injury	М	Worl	<br Yes 2 🔲	No					
Division of Vital Records,	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	289. Place (	of Injury - At home	, farm, sti	eet, factory	, office		28	Bf. Location (S City or Tow	treet and N	lumber or Rur	al Route Nun	nber,
Ö	al or s afte ii Dir	Certification;	4   Homicide	Dullain	g, etc. (Specify)						City of You	n, State)			
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	sai C	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exem	sicien: To the t	best of my knowled	dge, deat	h occurred	at the tim	ne, date ar	nd place, an	nd due to the o	ause(s) an	d manner as	stated.	· ·
	he Hi in 24 he Ft pletel	edicai	one)	and manne	er stated.	and/or in				WI OCCUITE					o/
	To t To t	Σ	29b. Signature and title of certifier	4	<b>k</b>				number				signed (Month,		
			· was	Mo	M	D	C	> 01	0 52	+22	-	0 2	1011	7000	*
	1041		30. Name and address of person who co				Print)	1/6/24		1.1	ure de	^	Da.	.1-	1
			seeing Chin,			nio	· / <del>)</del>	-ven	ne 1	Mar	vre de	-Gya	ce 1	11/2	1078
	Sta	ate	31. Date filed (Month, Day, Year)	32. He	gistrar's Signature	,	SEE . O		'						

Russem Richardson

			1- For Unpend Item #	State of Maryland / [ 23a&27 per me G8	Certificate of De	ath	Rec	2004	07550
	Physici	an	Decedent's Name (First, Middle, Last				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Medic		Janice E. S				FEBRUARY	4, 2004	10:20A. M
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Loca	ation of Death		4c. County of Dear	
		E	11441 RED JADE COL 5. Social Security Number 6. Se		LARGO	Jnder 24 Hrs.	8. Date of Birth	PRINCE GE	CORGES thplace (State or Foreign
	Funeral Director			7 M 01X F			May 2, 19	65 Shar	con, Pa.
land	M II		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
Man	투결	to	Maryland Prince Ge	eorges Upper	Marlboro				1ŽTYes 2 ☐ No
death with the Maryland	"natural", or Items 23e or 28e-f show edical Examinar mark be multipled at	Funeral Director	10e. Street and Number		10f. Zip Code		100	, Citizen of What Co	ountry?
th wit	23e C	aD	1441 Red Jade Cour	rt	20774			United St	ates
r dea	ems II III	iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispan If Yes, specify Cuban, M	nic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
afte	ar the		1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 🖾 No If Yes, Give		pecify:	. ,		
72 hours after	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				D1	ack
2 2	nat Lici	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of worki	ng 16	b. Kind of Business	Industry
within	than than	щ	Elementary/Secondary (0-12)	College (1-4or 5+)	Disabled				
2	Hygier other th	e Co	17. Father's Name (First, Middle, Last)			Mother's Name	(First, Middle, Ma	iden Sumame)	
d 2 should be file	sontal c sve	O B	Raymond V. Smithe	ers	J	June Bai	rbara Lee	· !	
shoul	nd M	1	19a. Informant's Name/Relationship (T	ype, Print) 19b	. Mailing Address (Street and N	Number or Rura	l Route Number, (	City or Town, State, 2	Zip Code)
nd 2	alth a 27 is r treu		Raymond V. Smithe	ers/ Father 23	13 Edmenton Dr	. Virg	inia Beac	h, Va. 2	23456
s ta	of Health and Mental Hygis f Item 27 is marked other r other treumatic svent, III		20a. Method of Disposition	cemete	f Disposition (Name of ry, crematory or other place)		ate 20	c. Location - City or	Town, State
Pages	Department of important: If it any injury or conce.		tx☐ Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify)	removal from State	gton National	Feb.	7,2004 Su	itland, M	ld.
Daltillore,	porta porta y inju		21. Signature of Funeral Service Licens	600	22. Name and Address of	Facility	Euneral	Homes	22212
n 8	9 2 2 9		Xeithy. San	ere MVIVES	5538 Marlb	oro Pike	Funeral	TITE, Md.	20747
			23a. Part 1. Pyter the diar a lay or comp shock, o heart failure. List only o	tions that caused the death. Do not be cause on each line.	not enter the mode of dying, su	ch as cardiac o	r respiratory arres		Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	Complication	s of multiple	scleros	sis		Onset and Death
	Medical kaminer		resulting in death)	Due to (or as a consequence					
	kanninei		Sequentially list conditions,	b					
P	sit	lue	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	Due to (or as a consequence	of):				
oo, be executed	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):				
	physician and s the burial-transit	alE		223 13 (31 23 2 3011334251133	o.,.				
UO I	attending phys	O		d					
₹ 90	oding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of del	ivery
death cer	atter 1 for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
at the	by the achec	Physician/Medi	9 Unknown	9□ Unknown					
	signed by the a be detached i	by PI	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
law requires t	been sig should b						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
N W	as bee 2 sho	olet					24a. Was an	24b. Were au	itopsy findings available
2 2	도 연	Completed					performe Yes 2	d? death?	completion of cause of
	certificate irector, pag	4	25. Was case referred to medical		26.	Place of Death	(Check only one)	7100	2010
93	this cer al direc	To B	examiner? 1∭ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Ou	0.4		A. J. State of the state of the	ce 6 Nother (Spec	cify) SCENE
	h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending		Firme of 28c. Injury at work?		28d. Describe how		
Attending	5 3	atlo	2 Accident investigation	(,, ,,	M 1 ☐ Yes	2 🗆 No			
Joy Attending	irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
و و	rel D. Iled ir								
Hosp	within 24 hours after death.  To the Funerel Director: A completely filled in by the fr	ical		sician: To the best of my knowledge iner: On the basis of examination an					
the	thin 2 the I	Medical	one)	and manner stated.	29c. License nun				
20	To Co		29b. Signature and title/of certifier	0,10			290	. Date signed (Monti	ii, Day, Fear)
			1 Charles	July .	O.C.M.E	Ξ	FEE	RUARY 5,2	004
	100								
	L		30. Name and address of person who c	ompleted cause of death (Item 23a)					2 04000
5.85	Sta	to.	30. Name and address of person who control of the state o	ompleted cause of death (Item 23a)	111 Penn St	reet, I	Baltimore	. Marylan	d 21201

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	Dhusiai		For State Registrar  1. Decedent's Name (First, Middle, Last,		-		of Death	2. Date of Deat	ng. No.	3. Time of Death
	Physicia /Medic	al	ELEANOR J.			T		MoJAN (		23;59 P
,	Examin Funeral Director	eı	WASHINGTON ADVI  5. Social Security Number 579-24-0874 6. Sec	ENTIST HOSPITA		T If Under 1	ACOMA PARK Year If Under 24 Hrs Days Hours Min.	8. Date of Birth	4c. County of MONT	COMERY 9. Birthplace (State or Fore VIRGINIA
Aarvland	show ad at	or	Usual Residence of Decedent  10a. State  MD  10b. County  PRINCE GI	EORGE 10c. Cit	ty, Town or Le		VERDALE			10d. Inside City Lim
h with the	23a or 28a- at be notif	al Director	10e. Street and Number 4409 EAS	WEST HIGHWAY	Y	10f. Zip (	ode 20737	10	Og. Citizen of Wr	nat Country?
within 72 hours after death with the Maryland	al', or Items Statisfices on	by Funeral	11. Marital Status  1    Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decede If Yes, specifi 1 Yes 2	nt of Hispanic Origin? (S y Cuban, Mexican, Puer No <i>Specity:</i>	pecify Yes or No- to Rican, etc.)		- American Indian, White, etc.
within 72 ha	ene. than "natur ite Medical I	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual kind of work DO NOT use	done during most of wo	rking	RESTAUR	
helif he filed	Aental Hygi rked other tic event,	To Be Co	11 TH 17. Father's Name (First, Middle, Last)	UNKNOWN				me (First, Middle, M		
S should	and le me	i d	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (	Street and Number or Ru	ural Route Number,	City or Town, S	tate, Zip Code)
prent Panes 1 and	ヹ゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙゙	31	SARAH M. SMTT  20a. Method of Disposition  143 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Sign full of Funeral Sen Ce Lights	Removal from State	Place of Disposers Place of Disp	osition (Name SZP115 RY		Date N 13,04	20c. Location - C ATLANTH	
	/Medical xaminer fransit as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complishes, or heart failure. List only of immediate Gause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	ne cause on each line.	ARDIAL quence of):	ter the mode			-	Approximate Interval Between Onset and Death
the death cart	attendin for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3[	⊒Ectopic pre ⊒ Other (spe			23d. Date Mont	•
requires that the death cert	been signed by the should be detached		Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	inderlying ca	use given in Part I.			ute to the cause of death?
The law	N D N	Completed						24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy findings availa or to completion of cause of ath? Yes 2 X No
Physician.	s certii lirecto	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 🗹	ER/Outpatie	nt 3 🗆 DO/	Other	ath <i>(Check only one</i> dome 5 ☐ Reside		(Specify)
Attending Phy	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		c. Injury at Work? 1 Yes 2 No	28d. Describe ho		
5	urs after de erat Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			City or Town	, State)	or Rural Route Number,
Introduction of	24 hours a Funeral etely filled	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
Totho	within 2 To the	Me	29b. Signature and title of certifier	2		29c.	License number 35427		JAN 7,20	(Month, Day, Year) )04
1	5)		30. me a d address of person who c				OMA PARK MD			

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and	Mental Hygie		0423
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last, JOHN C. SMITH  4a. Facility Name (If not institution, give	street and number)  S Hospital		che	or Location of Death		Day Year 18 204 4c. County of Death Prince 6	
	Funeral Director		5. Social Security Number 6. Sec. 247–60–6876 18	SH 2DE	last birthday) 52. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y	9. Birthp Cour 1941 Gree	place (State or Foreign http) enville, S
	ith the Maryland or 28a-f ahow to retiffed at	Director	D.C. 10b. County D.C		y, Town or Lo			10g	. Citizen of What Cour	Od. Inside City Limits 1 ☑ Yes 2 ☐ No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hydiene. Department of Heatih and Mental Hydiene.  Department of Heatin 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event. Its Madical Exertil as must be notified at once.	by Funeral Director	4610 G St. S.E.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:		20019 Was Decedent of Hill Yes, specify Cubin	dispanic Origin? (S an, Mexican, Puert Specify:		Inited Stat  14. Race - Americ Black, White,  Specify: Blace	ean Indian, etc.
21215-0036	within 72 hor ene. than "natura tha Modical E	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 10th	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	eation during most of wor d)	king 16	b. Kind of Business/Ind	
Maryland 2	ould be filed Mental Hygi Marked other hatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Unknown				Gladys k		,	
, Mar	and 2 sh eaith and m 27 ts m		19a. Informant's Name/Relationship (Ty.) Patricia Jenkins		4610	G St. S.	E. Wash.,	D.C. 200	ity or Town, State, Zip 19	Code)
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		20a. Method of Disposition  1 □ Spurial 2 □ Cremation 3 □ R  4 □ Dopation 5 □ Other (Specify)  21. Sign ture 7 Funeral Service □ cens	Lin	coln M	sition (Name of natory or other place emorial (	Cem. 1-24	-04 Su	c.Location - City or To itland, Md Mortuary I	
ñ	Depa (mpo		23a. Part1. Enter the disease, of complishock, or heart failure. List only on	WW July				N.E. Was	h., D.C. 2	0002 Approximate
,007	Cate be executed by Action 1975 Street by Action 1975 Street and Action 1975 Street Branch 1975 Street Branc	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading to in recibile cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					Interval Between Onset and Death
	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decadent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
ords, P	es this	þ	Part II. Other significant conditions con	tributing to death but not rest	ulting in the un	nderlying cause give	en in Part I.		co use contribute to the	
ř	ate h page	e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2	? prior to com	sy findings available inpletion of cause of 2 No
VISION OF	tending Physical After this the funeral dis	Certification; To Be	examiner?	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hobiding, etc. (Specific	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	er: 4 Nursing Ho	28d. Describe how in 28f. Location (Street	and Number or Rural	
_ :	Hospital 4 hours Funeral ely filled	ledical Cer	29a. Certifier 1 Certifying Phys	cian: To the best of my known; On the pasts of examinat	wledge, death	occurred at the timestigation, in my op	ie, date and place, pinion, death occur	and due to the cause red at the time, date	o(s) and manner as at	ited. the cause(s)
	To the complete	Mec	29b. Signature and title of certifier	for the grant of t		29c. License	number	29d.	Date signed (Month, D	Pay, Year)
	Star Registra		30. Name and address of person who con Salvado Silve 1 31. Date filed (Month, Day, Year)  AN 2 7 2004	npleted cause of feath (Item 30. Registrar's Signal	spei Ta	Print)  Drive	che.	verly 1	want Im	√ વ <u>ૈ</u>

			For State Registrar	State of Mary	land / Depa		lealth and N	Mental Hygi	_	4 04232
	3.	Ш	Decedent's Name (First, Middle, Last,	)				2. Date of Death		3. Time of Death
	Physici		Ronald B. Slyke	ρ				Month January	20 2004	. M
1	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	January	4c. County of De	
4.1			Prince George's		ospital		Cheverly		Princ	ce George's
	Funeral	11	5. Social Security Number 6. Set	x 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
u.	Director		577-52-3123	XM 2□ F	66 Yrs.	Months Days	Hours Min.	Oct. 12,		Vash., DC
	pu *		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo					
	eho eho	5			. City, Town of Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N	Director	Maryland Prince (	Georges'			ellville	1	· ·	1
	with a or	ā				10f. Zip Code		10	g. Citizen of What	Country?
	eath	Funeral	1722 Albert Dri	12. Was Decedent Ever	in II S 12		20721			I States
	ther d	Fun	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 X Yes 2 □ No	10.5.	If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wi	
980	urs al	þ	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify: ]	31ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow ta Medical Examiran must be notified at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Busines	ss/Industry
21,5	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ing		
2	gien.	Con	12th			rinting	Superviso	r	Gover	nment
p	be filed ital Hygid d other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma		
yla	should to nd Ment marked umatic e	10	Alexander Sly	yke		1		Mable (	Cook	
Maryland	2 she and is my		19a. Informant's Name/Relationship (Ty				and Number or Run			, Zip Code)
	and ealth m 27		Carla M. Slyke -		Access to the control of the control		Drive, Mi		11e, MD	20721
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, It a Medical Examinat must be notified at once.		20a. Method of Disposition 1	temoval from State	b. Place of Dispo cemetery, crei	sition (Name of natory or other and	lev [	Date 20	Oc. Location - City of	or Town, State
Ë	men tant: jury		`4 Donation 5 Other (Specify)	M	laryland	National	Mem. 1/2	6/2004	Laure1	, MD
3al	permit. Departr Imports any inju		21. Signal re of Funeral Service Licensi	98	22		ss of Facility St			
_	70740			ewal Th			enning Rd			20019
	Pnysician /Medical		23a. Part (Lenter the disease, or complishook) or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.			ig, such as cardiac of FARCTION SENSE		st,	Approximate Interval Batween Onset and Death
B	Examiner		Sequentially list conditions	CORONAR	ART	ERY DI	SEXSE			
	D ≒	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con						
	ate be executed hysicien and he burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	HRTER1057		5				
760,	sien s	Ē	resulting in death) Last	Due to (or as a con	sequence of):					
	ate to	licai		J						
x 68	The law requires that the death certifica lie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:	2- 14						
Вох	atten for us	lan	in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of di Month	elivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				,
Ω.	that the	P	Part II. Other significant conditions con	stributing to death but not	resulting in the ur	ndertving cause give	en in Part I	23a Did toba	cco usa contributa	to the cause of death?
ds,	sign d be	d by	·	•		ioon, my oacco give				Probably 4 Dunknown
Ö	w requires that been signed be should be det	ete						-		· <del>-</del>
Records,	has has	Completed						24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
_	iician: Th certificate rector, pag		25.14	<del> </del>				1 ☐ Yes 2.	No 1 ☐ Ye	s 2 No
Vital	ysician: The iis certificate ha director, page	o Be	25. Was case referred to medical examiner?	lospital:	~	Oth	26. Place of Death			·
o	£ 5 %	- 1	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2X ER/Outpatien 28b. Time of	. SEI DOA	4 Indising Hor	ne 5 🗌 Residend 28d. Describe how	ce 6 □Other (Sp	ecify)
o	ding h. Afte fune	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	28c. Injury Work	(?` Yes 2 □ No	Edd. Describe flow	injury occurred	
Division	or Attending Patter death. Director: After in by the funera	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	t home farm stre			28f Location (Street	et and Number or F	Rural Route Number,
2	i g if o	Certification;	4 Homicide determined	building, etc. (Sp	ecify)	out, ractory, ornos		City or Town,	State)	iorar noble rolliber,
	Hospitel or / 24 hours after Funerel Dire etely filled in b		29a. Certifier (Certifying Phys	sician: To the best of my	knowledge, death	occurred at the tim	ne, date and place a	and due to the caus	ea/e) and manner a	e stated
	To the Hospitel within 24 hours a Tokhe Funerel I completely filled	Medical	(Check only 2 Medical Examination)	ner: On the basis of exame and manner stated.	nination and/or inv	estigation, in my or	pinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
	To the Vithin 2 To the complet	Me	29b. Signature and title of certifier	d 0 0		29c. License			l. Date signed (Mon	ith, Day, Year)
•	1-		+ Ankor	(C. 1. W)	I want	1	134 13		1-22	-04
1	(10)	1	30. Name and address of person who co	m ted cause of death (	Item 23a Type	Print)	_ //	0	1-22. 4 MD	
-			HECTOR COSH SON		300 H	FIAL	DR	CHENERL	Y MD	20185
	Sta	e	31. Date filed (Month, Day, Year) JAN 2 7 2004	32. Registrar's Si	ture				/	
1	Registra	ar	JHN & / 2004	en 15 1	The same					

			For State	State of Ma	ryland / Dep		lealth and M	lental Hy	_	04233
	53:		Registrar     Decedent's Name (First, Middle, La	est)		Timodio oi		2. Date of Dea	ath	3. Time of Death
	Physici		Balkar	Singh				Janua	Day Year	4 10 am
	/Medic Examin		4a. Fecility Name (If not institution, gr			4b. City, Town, o	r Location of Death		4c. County of Dea	
			Doctors Community	/ Hospital		Lanham			Prince G	leorges
10	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) Jan 1	h 9. Biri	hplace (State or Foreign
d.,	Director			(X <sup>M</sup> <sup>2□</sup> F 70.	Yrs.			Jan 1	1934   Pak	istan India
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
7	e Maryl Ba-f sho	ctor	Maryland Prince	Georges	Bowie					1XAYes 2 □ No
Balka	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It idem 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Marilan Exam	by Funeral Director	3909 Kencrest Ct	•		10f. Zip Code	20721		10g. Citizen of What Co India	ountry?
0	dea	ner	11. Marital Status	12. Was Decedent E- Armed Forces?	ver in U.S. 13	. Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Singh, 21215-0036	urs after al', or the	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify: Whi	
ر 200	2 hou	Completed	15. Decedent's E (Specify only highest gi	ducation	16a. Dec	edent's Usual Occup	pation	na	16b. Kind of Business	
25.4	e. en r	nple	Elementary/Secondary (0-12)	College (1-4or 5+	-)	e kind of work done DO NOT use retired	d)	,,g	Calf Empl	avad
	filed with Hygiene. other ther	S	12	0	M	achinist	40 14-15-1-11-	(Fine Minds	Self-Empl	oyeu
, br	2 should be filed and Mental Hygi is marked other aumatic event, I	Be	17. Father's Name (First, Middle, Las	t)					Maiden Sumame)	
<u>8</u>	should be ind Mental I	ဥ	Baghat Singh  19a. Informant's Name/Relationship	(Type Print)	10h 14a	ling Address (Street		aur Navia Aumba	r, City or Town, State,	Zio Codel
Maryland	d 2 st th and 17 is n traun		Havinder Singh	(Son)		Kencrest				LIP COOE)
	of Health of Health litem 27 i		20a. Method of Disposition		Ont Disease of Disease			)	20c. Location - City or	Town, State
ē	Pages nent of I int: If it		1 ☐ Burial 2 🂢 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Chesapea	Ke Cremat	8ry 01/26	/04	Beltsville,	MD
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of once.		21. Signature Ineral Service Lice	9-				475.00.13		
ä	permit. Departr Importa		> husand	Mans		9013 Anna	polis Rd.	Lanhai	m, MD 20706	i
•	Physician /Medical Examiner	٠	23a. Part Enter the disease, or cor sh, ck, or heart failur List on Immo late Cause (Final disease or condition resulting in death)	a. TU		nter the mode of dyir			rest,	Approximate Interval Between Onset and Death
3760,	ate be executed hysician and the burial-transit	IIcal Examiner	Sequentially list conditions, if any, leading to this edition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
.O. Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Effector: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the g□ Unknown	Fetal death 3	☐Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
Division of Vital Records, P.O.	w requires that s been signed b		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.		obacco use contribute to	the cause of death?
Reco	The law re- te has bee age 2 sho	Completed	Corone	vy art	ery d	Beare		24a. Was autop perfo		utopsy findings available completion of cause of
ta	ysician: The l is certificate ha director, page	Ф	25. Was case referred to medical				26. Place of Deat		<del></del>	7.5110
<u> </u>	ysici	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatier	nt 2 P/Outpati	ent 3 DOA Ott	ner: 4 🗌 Nursing Ho	me 5 Resid	lence 6 ☐Other (Spe	city)
ō	ding Phys h. After this funeral di		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time		y at rk?	28d. Describe h	now injury occurred	
.0	endir sath. or: Al	atic	2 Accident investigati				Yes 2 □No			
Ξ	at or Attending P s after death. I Director: After to in by the funera	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Inju- building, etc.	ry - At home, farm, : . (Specify)	street, factory, office		28f. Location (5 City or Tox	Street and Number or R vn, State)	ural Route Number,
۵	To the Hospital or Attendl within 24 hours after death. To the Funeral Circator. a completely filled in by the fu		(Check only 2 Medical Ext	Physician: To the best o	examination and/or	ath occurred at the ti	me, date and place, ppinion, death occur	and due to the	cause(s) and manner a date and place, and du	s stated. to the cause(s)
	To the I	Medical	one) 29b. Signature and title of certifier	and manner stat	ed.	29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
	Visit of the second of the sec		250. Orginature and title of Certifier	MS			00569		/2	/ 1
	00		31. Name and application of person and		are their titles of				112410	7
	90			1 anh	1/		8 Good La	k Road	Lanhan M	neiland
Í	Str	ate	31. Date filed (Month, Day, Year)		r's Signature			N. 1.4 B. W.	7.17	J
	Regist		JAN 2 7 2004	Sleeve It	Soule					

			1 - For State Registrar			Depart		Health an		iene <sub>93. No.</sub> 2004	04234
	Physic	ian	Decedent's Name (First, Middle, La     CLITTEL EX		CITIE	0001			2. Date of Deat Month	Day Year	3. Time of Death
· A	/Medi Examii	cal	4a. Facility Name (If not institution, giv	LAWS e street and number)  NOVA MODE		OBEL 4t		or Location of D		4c. County of Deat	7
	Funeral Director		5. Social Security Number 6. S 214–32–0363 Usual Residence of Decedent	Sex 7. Aga □ M 2 1 F	69 (In yrs. last t		Under 1 Year onths Days		Ain. (Month, Day,	9. Bin 9, 1934 Mar	hplace (State or Foreign untry) yland
	72 hours after death with the Maryland hatural; or Items 23a or 28e-1 show dical Examiner must be notified at	Funeral Director	10a. State 10b. County  Maryland Wicomi  10e. Street and Number	co	10c. City, To Sal	isbury			11	0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
	th wit	<u>e</u>	7578 Hogans Lane				21801			USA	
980	be filed within 72 hours after death with the Manylan tal Hygiene. Id other then "natural", or items 23a or 28e-1 show other then "natural", or items 23a or 28e-1 show event, the Madral Excitation at	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Amed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Decedent of ss, specify Cut		(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify: W	
1215-0	within 72 ho lene. Ithen "natur the Woolcal	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5		(Give kind	's Usual Occu d of work done NOT use retire	during most of	working	16b. Kind of Business/	•
Maryland 21215-0036		To Be Cor	12 17. Father's Name (First, Middle, Last, Percy Laws	-	S	ecreta	ary	18. Mother's I	Name (First, Middle, M Haddock		ter
	nd 2 shaith and 27 is m	1	19a. Informant's Name/Relationship ( Fred L. Strobel/		19				Rural Route Number, Salisbury,	City or Town, State, 2	ip Code)
Baltimore,	nit. Pages 1 and artment of Heatt ortent: If item 2 injury or other 1		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)		cemet		n (Name of ry or other pla Cremato		3)	20c. Location - City or Salisbury,	
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Lice	beines OF	TP	501	Snow	Hill Rd	., Salisbu	essional A ry, MD2180	ssociation
j.	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	plications that caused one cause on each line.  a	nay 1	J. Ten	e mode of dy	eng, such as card	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	Ilcal Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a							
P.O. Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal deat		opic pregnanc ner (specify)	/		23d. Date of delin Month	very Day Year
ords, F	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significant conditions of		t not resulting	in the under	lying cause giv	en in Part I.		accoluse contribute to	
al Records,	n: The law r icate has be r, page 2 sh	Completed							24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
⋚	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	2 )		Oth		eath (Check only one		
ō	Phys rthis raldi	<u>1</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatien		utpatient 3 Time of	DOA 28c. Injur	4 Nursing		nce 6 Other (Speci	fy)
Division of Vital	tending leath. tor: After the tune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day	Year)	Injury N	Mor 1 □	yat k? Yes 2 □ No	28d. Describe how	v injury occurred eet and Number or Rur	al Pouto Number
2	후		4 Homicide determined  29a. Certifier 1—Certifying Ph	building, etc.	(Specify)			ne date and pla	City or Town,		
	To the Huspitel within 24 hours a To the Funeral I complete y filled	Medical	one)	iner: On the basis of e and manner state	examination ar	nd/or investig	gation, in my o	pinion, death oc	curred at the time, dat	te and place, and due t	o the cause(s)
	Twith To	~	29b. Signature and title of certifier				29c. Licens	MOJIC B number	29	d. Date signed (Month,	Day, Year)
26	Q = 1		30. Name and address of person who to	1	if e 60		Salisi	bury	MD 218	04 Stever	Harne
15.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar		4	Spork	2		, 5.000	

DHMH 17 Rev 1/2001

Shirley Strobel 214.32-0363

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day **Physician SMACK** WILLIAM **EDWARD** JAN. 16, 2004 /Medical 1 AM 4a Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Salisbury Rehab and Nursing Center Salisbury, Md. Wicomico If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) JULY 24, 19 5. Social Sacurity Number 6. Sax 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Hours Months Days Country) DELAWARE 58 1945 215-44-6252 Director Usuel Rasidance of Dacedant filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yas 2 □ No Director MARYLAND WICOMICO WILLARDS 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 7328 DIVISION STREET Funeral 21874 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yes, Give Year or Datas: 1966-68 13. Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Navar Marriad 2 X Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à Specify: 3 Widowad 4 Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad) 15. Decedent's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry I Hygiana. Elemantary/Secondary (0-12) Collega (1-4or 5+) 9 MECHANIC COUNTY Depertment of Haalth end Mantel Hygis Important: If Itam 27 is marked other 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be **SMACK** WILLIE H. ALBERTA JONES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) JUDY T. SMACK/WIFE 7328 DIVISION STREET, WILLARDS, MARYLAND 21874 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1/20/04 NEW HOPE CEMETERY WILLARDS, MARYLAND 21. Signature of Funeral Service Lice see 22. Name and Addrass of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part. Enter the dis asa, or complications that cause the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Intarval Betwaan Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in daath) Examiner Due to (or as a consequence of): Physician/Medical Examiner mell The law requiras thet tha death certificate be executad Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consaquence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown ۵ Completed 24b. Wara autopsy findings availabla prior to complation of causa of deeth? 24a. Was an autopsy performed? s certificata has t director, page 2 s 1 Tas 20 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa rafarrad to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 Yas 2 No Other: Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) After this 27. Mannar of Death 28a. Date of Injury (Month, Dey Yaar) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Panding daath. 2 Accidant invastigation 1 ☐ Yes 2 ☐ No the Director 6 Could not be detarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicida To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 0 33085 30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) 13 5, hartes my 1346 S. Division St. Suite, Salisbury, Md. 21804 10 WICh

State Registrar **DHMH 16 Rev 6/95** 

31. Data filad (Month, Day, Yaar)

JAN 22

2004

SMACK

EJ.

MILLIAM

32. Registrar's Signature

		Amend Item #23a State of Maryland /Department of Health and Certificate of Death	Mental Hygiene
		1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physicial	DAKKI C. SI.C.P.L.C.K	Month Day Year
	/Medica Examine	4. Facility bloom of and track attack attack and an advantaged and and an advantaged attacks at the contract of the contract o	Jan. 21, 2004 3:30 PM Location of Death 4c. County of Death
9)	E Addition		ry, Md. Wicomico
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs	8. Date of Birth 9. Birthplace (State or Foreign
	Director	176-34-9904 61 Yrs.	APR. 17,1942 LANCASTER, PA
	pu >	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	sho del		11 Yes 2 □ No
	vith the Ma	DELAWARE SUSSEX SEAFORD  10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	ath with the Marylan 23s or 25s-f show		
	within 72 hours after death with the Maryland ane. than "natural; or items 23s or 28s-f show he Medical Exertines must be notified at	8470 GUM BRANCH ROAD 19973 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Opecify Yes or No- 14. Race - American Indian,
	fter dea inerma	Armed Forces? If Yes, specify Cuban, Mexican, Puer  1 □ Never Married 2 □ Married 1 □ Yes 2 2 No	to Rican, etc.) Black, White, etc.
07	urs aff	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	Specify: WHITE
2-0	n 72 hours natural', edical Exa	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER	16b. Kind of Business/Industry
7	thin.	Elementary/Secondary (0-12) College (1-4or 5+)	ixing
7	ed will will be the state of th	TRUCK DRIVER	LONG -DISTANCE TRUCKING
Pu	be filed tal Hygi d other event,	17. Father's Name (First, Middle, Last)  18. Mother's Nat	me (First, Middle, Maiden Surname)
Maryland 21215-0020	d 2 should be filed within the and Mental Hygiene. 7 le merked other than traumetic event, the M		M. SHIFLET
Jar	2 shot and h is mai		ural Route Number, City or Town, State, Zip Code)
	l end lealth m 27 her t	EILEEN D. STAUFFER/ SISTER 8470 GUM BRANCH ROAD,  20a. Method of Disposition   20b. Place of Disposition (Name of	
Baltimore,	Pages 1 end nent of Healt int: if Item 23 iry or other	20a. Method of Disposition  1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  EASTERN SHORE	Date 20c. Location - City or Town, State
Ë	0 0 5 5	4 Donation 5 Other (Specify) CREMATORIUM	LEWES, DELAWARE
Bal	permit. Pa Depertmen Important: any injury once.	21. Signature Funeral Service Licensee M00866 22. Name and Address of Facility PARSELL FUNERAL HO	MES HARDESTY CHAPEL
	70 = 4 Q		RIDGEVILLE, DE 19933
1	Physician /Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  a.   Due to (or as a consequence of):	Interval Between Onset and Death  3 months
8760,	sate be executed bhysician and the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):	
Box 68	h certificate ending phy r use as the	resulting in death) Last	
<u>.</u>	deat he att ed fo	Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
, P.O	s thet the ned by the e detach		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Madical Certification: To Be Commissed by Dhysician Madical		24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	The ete h		1
ita Ita	stan: artific ctor,	25. Was case referred to medical examiner? 26. Place of Dec	ath (Check only one)
=	hysic his co		lome 5 ☐ Residence 6 ☐ Other (Specify)
ion	Attending Physician: or death. ector: After this certific by the funeral director,	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 38c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
Divis	al or Atters at a strength of in by the	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Atending Physis within 24 hours after death.  To the Fureral Director: After this completely filled in by the funeral director.  Maclical Cartification: To	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place control of the basis of examination end/or investigation, in my opinion, death occurred and manner stated.	o, and due to the cause(s) and manner as stated. Irred et the time, date and place, and due to the cause(s)
	Fo the vithin comp	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Dey, Year)
	- > - 0	Phoase M.D. 029168	1/22/04
	\	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/
XX	{	POBERT ALLEN, M.D. 1346 S. Division	St.Suite, Salisbury, Md.21804
	State Registrar	31. Date filed (Month, Day, Year)  JAN 2 7 2004  32. Registrar's Signature  JAN 2 7 2004  JAN 2 7 2004	
	2.	JAN A L LOS I	

			1 - State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment tificate			and M	R	leg. No. 4	04	0 1: 2:	37
	Physici		1. Decedent's Name (First, Middle, Last)  Arlanta P. Showell	L						2. Date of Dea Month Jan	Day	Year 2004	3. Time of Dea	ith PM
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)				Location o	f Death		4c. County		J	
			527 Bay Street	7.4	(la ven la ek himbalavi)	Ber If Under		If Under 2	24 Hrs	8. Date of Birth		cest		:
ı	Funeral Director		5. Social Security Number 6. Sex 1□	M 200 E	(In yrs. last birthday) 6 Yrs.	Months	Days	Hours	Min.	May 6,	(Year)		place (State or Fo. htry)	өідп
	pug *		Usual Residence of Decedent  10a. State 10b. County		IOc. City, Town or Lo	cation						1.	10d. Inside City Li	mits
	Maryis	to	MD Worcester		Berlin								1 Yes 2	
	th the	irec	10e. Street and Number			10f. Zip	Code			1	10g. Citizen of V	Vhat Cou	ntry?	
	ath wi	ral	527 Bay Street				811				U.			
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-f show any injury or other traumatic avent. I'm Medical Evaniral rural be routified at ODGe.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ev Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ol>		Was Deced f Yes, spec 1 ☐ Yes 2			gin? (Spe , Puerto f	city Yes or No- Rican, etc.)	14. Rac Blac Specify	k, White,	can Indian, etc. a <b>ck</b>	
21215-0036	72 ho	Completed	15. Decedent's Educi (Specify only highest grade		16a. Deced	kind of wor	k done d	durina most	of workin	ng	16b. Kind of Bu	siness/In	dustry	
121	within ene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT us D	omes				Privat	e Fa	milies	
פֿב	e filed al Hygi other vent, I	3e C	17. Father's Name (First, Middle, Last)						r's Name	(First, Middle,	Maiden Sumam			
ylaı	outd b Ments arked	To Be	Charles Purnell						Leon					
Maryland	d 2 sh th and th sm 7 Is m traum		19a. Informant's Name/Relationship (Typ Mable Jarmon/daugh			-				Route Number	r, City or Town, <b>Q11</b>	State, Zip	Code)	
ē,	s 1 an if Heal itam 2 other		20a. Method of Disposition	-	20b. Place of Dispo	sition (Nam	e of	- 1		Company to the same	20c. Location -	City or To	own, State	
Ê	Page nent o ant: If ury or		1 Surial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State	St. Paul'				/24/	2004	Berlin,	MD		
Baltimore,	permit. Departimportiany inji		21. Signature of Funeral Service Ucenser  23a. Rart1. Enter the disease, or complic		L	ewis 1	N. W	s of Facility atson Rd	Fun	eral Ho	me MD_ <b>21</b> 80	1		
	Physician /Medical		23a. Rart1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line.  Duty  Due to (or as a.	ne death. Do not ente	er the mode	e of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Betweer Onset and Deat	1
,8760,	The law requires that the death certificate be executed as has been signed by the attending physician and agge 2 should be detached for use as the burial-transit or	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a d	consequence of):	Um								
P.O. Box 6	that the death certific ned by the attending p detached for use as f	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 profiths? 1 □ Yes 2 Deno 9 □ Unknown	c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	☐Fetal death 3☐	Ectopic pre Other <i>(sp</i> e					23d. Dat Mo	e of delive	ery Day Year	
	quires that n signed b uld be deta	by	Part II. Other significant conditions cont	ributing to death but	not resulting in the ur	nderlying ca	ause give	en in Part I.		23e. Did to	~	ribute to th	he cause of death pably 4 DUnkn	
Division of Vital Records,	The law requir ate has been si page 2 should I	Completed								24a. Was a autops perform	med2	Vere auto prior to co leath?	psy findings avail mpletion of cause 2 No	able of
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Otho			(Check only on				_
on of	ding Phys n. After this funeral di	ıtlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Time of		Bc. Injury Work	4 LI Nui	2		ence 6 Other		(y)	
Divisi	al or Attandi s after death. Il Director: A id in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	eet, factory	, office		2	8f. Location (Si City or Town	treet and Numb n, State)	er or Rura	al Route Number,	
	To tha Hospital or within 24 hours after or To the Funaral Dir completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying Physical Cartifornia) 2 Medical Examination	cian: To the best of er: On the basis of e and manner state	xamination and/or inv	occurred a restigation,	at the tim in my op	ne, date and pinion, deat	d place, a h occurre	nd due to the cod at the time, d	ause(s) and ma ate and place, a	nner as s and due to	tated. the cause(s)	
	To the To the comp	Σ	29b. Signature and title of certifier	11	1 5	1		number			9d. Date signed			
			No fra	104,	M-D.	2-1-1)	07	874	8		1-	21-	- 04	
			30. Name and address of person who con	V 2AUF 2	in (item 23a) (Type,	314	F	RANK	clin	AVE	BE	FRLA	-04 1,60218	17
and the second	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 2	004 32. Registar	s Signature	g pa	pa	KN					1	1

	= State Registrar	d / Department of Health and Mental H Certificate of Death	lygiene Reg. No. 2004 04238
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  ETHEL M SPERT  4a. Fecility Name (If not institution, give street and number)  Doctor's Community Hospital	4b. City, Town, or Location of Death	PAY Year 2004 10:05 PM 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. 1 M 2 XF 89  Usuel Residence of Decedent	Months Dave Hours Min (Month	Prince George's  Birth Day, Year)  9. Birthplace (State or Foreign Country)  4, 1914 West Virginia
urs after death with the Maryland urs after death with the Maryland all; or terms 23a or 28a-1 show and increase be notified at by Funeral Director	MD Prince George's Box  10e. Street and Number  2803 Barberry Lane  11. Marital Status   12. Was Decedent Ever in U. Armed Forces?   1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 1 \( \text{Never Married} \) 2 \( \text{Married} \) 1 \( \text{Never Married} \) 1 \( Never Married	y, Town or Location  wie  10f. Zip Code  20715  S.   13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)  1   Yes 2   No Specify:	10d. Inside City Limits  1 □ Yes 2 1 No  10g. Citizen of What Country?  USA  No-  14. Race - American Indian, Black, White, etc.  Specify: White
o filed within 72 ho al Hygiene. I other then "naturi vent, the Medical I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  12  College (1·4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Government Employee  18. Mother's Name (First, Midd	16b. Kind of Business/Industry  U.S. Government
and 2 should and 2 should and 2 should and Mer market her traumatic	Harry Hart  19a. Informant's Name/Relationship (Type, Print)  Brian Sperty / Son  20a. Method of Disposition  20b. P	19b. Mailing Address (Street and Number or Rural Route Num  7202 Kings Arm Drive, Manass Place of Disposition (Name of emelery, crematory or other place) Therm Virginia	20c. Location - City or Town, State
permit. Pages 1a Department of Hee Important: If item sny injury or othe	21. Signature of Funeral Scruiss In Free  M00956  23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	Northern Virginia Funeral 14522L Lee Road, Chantill Do not enter the mode of dying, such as cardiac or respiratory	O4 Chantilly, VA  I Services Ly, VA 20151  Approximate Interval Between Onset and Death
certificate be executed dring physician and use as the burial-transit	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition o	uence of):	
death certific e attending p d for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown  23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
v requires the been signed should be of eted by	ARRHYTHM IA	10	d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
The ate he page	25. Was case referred to medical examiner?	au pe 1 □ Yes 26. Place of Death (Check onth	topsy prior to completion of cause of death formed death of the total to
ng Pt ter the neral neral	1 X npatient 2	Injury Work?  M 1 Yes 2 No	e how injury occurred
To the Hospital or Attandit within 24 hours after death.  To the Funaral Director: At completely tilled in by the funaral Director. Medical Certification		whee, farm, street, factory, office  28f. Location City or 7  wheedge, death occurred at the time, date and place, and due to the time and/or investigation, in my opinion, death occurred at the time.	(Street and Number or Rural Route Number, Fown, State)  The cause(s) and manner as stated.  The cause(s) and place, and due to the cause(s)
To the H  Within 24  To tha F  complete	29b. Signature and title of certifler  - M  30. Name and address of person on completed cause of death (Item	29c. License number	29d. Date signed (Month, Day, Year)  1 28 04-  22/4 MB 20740
State Registrar	ADEBOVIALE ATAYI 6201 GRE  31. Date filed (Month, Day, Year)  JAN 29 2004  JAN 29 2004		RK MD 20140

	1- State of Maryland / Department of Heal Certificate of Department	eath	Reg.	200	7 0 40 / . 1
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  Martin Francis Simons  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local	J	2. Date of Death Month January	Day Year 19, 2004	3. Time of Death 6:45p M
Funeral Director			B. Date of Birth (Month, Day, Yes	Montgo 1924 IRA	mery thplace (State or Foreign wintry)
within 72 hours after death with the Maryland jiene. If then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at commission by Funeral Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Va.   FAIRFAX   Mclean   10b. Street and Number   10f. Zip Code   22102   11. Marital Slatus   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispar	nie Origin? (Speci	τ	Citizen of What Co	
ed within 72 hours after d yglene. her than 'natural', or iten it, the Medical Examiner	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	Specify:	166	Black, White	white
offiled of Hygin of her control of h	17. Falher's Name (First, Middle, Last)	. Mother's Name (i	First, Middle, Maid	· · · · · · · · · · · · · · · · · · ·	7-0-4-1
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury ocother traumatic and ince.	Jennifer Simons Walther/daug. 15245 SE River S  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of 5130 Wisconsi:	Date Dri Jan.27,	tve, Vanc ,2004 Al	cover, WA. Location - City or Lexandria er's Sons	98683 Town, State , Va. , Inc.
Physician /Medical Examiner  Physician and physician and physician and physician and physician and physician Examiner  Cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, surshock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Pneumonia  Due to (or as a consequence of):  Stroke				Approximate Interval Between Onset and Death 24 hrs
iries that the death certificate signed by the attending phys d be detached for use as the d by Physician/Medic	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of dei Month	ivery Day Year
w requires that been signed be should be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.			the cause of death?
The law ate has b page 2 sl			24a. Was an autopsy performed 1 Yes 2 🛣	? prior to death?	topsy findings available completion of cause of
Jing Phys	examiner?  1  Yes 2 No	280		6 Other (Specially)	eify)
spital or ours afte teref Dir filled in I	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  1 Continue of the time, day the	late and place, and	City or Town, St	e(s) and manner as	stated
To the Hosp within 24 hou To the Funel completely fill Medical	(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.  29b. Signature and title of certifier  29c. License num	n, death occurred	at the time, date a	and place, and due  Date signed (Month	to the cause(s)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Aruna S. Nathan, MD., 11125 Rockville Pike #208,  31. Date filed (Month, Day, Year)  JAN 28 2004  32. Registrar's Signature	, Rockvil	le, Md.	20852	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State
Registra/MFNDFD#23a(c)perMD2/2/MFAW,McCc Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15, January 2004 Kathryn G. Simon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince Georges Laurel Regional Hospital Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 03/21/1909 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Vrs 94 216-46-9263 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Hygiene. Uther then "neturel", or flems 23e or 28e-f show ent, the Medical Examinet must be indiffed at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20814 U.S.A. #221N Funeral 5225 Pooks Hill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 ♥ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: if Item 27 is marked other th
any injury or other traumatic event, in
pores. other 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Ellis Tillie Bell Hyatt Weinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin V. Simon/Son 6548 Windermere Circle, Rockville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns. 01/18/2004 Falls Church. Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Manda 1091 Rockville Pike, Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on a cut line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Hypothermia Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine inding physician and use as the burial-transit The law requires that the death certificate be executed ALTERED MENTAL STATE Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1□ Yes XXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ After this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatura! 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of c 29c. License numbe 321 10 who completed cause of death (Item 23a) (Type, Print) NICHOLAS AZINGE, 6201 GREENBELT RD. #M-17, COLLEGE PARK, MD 20740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	arylan	•			ealth a Death	and M		Reg. No	2001	04241
	Physicia	20	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	y Year	3. Time of Death
	/Medic		Catheri		im						Januar		, 2004	7:10 P M
	Examin	er	4e. Fecility Name (If not institution, give :		7.0				Location o	of Death			County of Dea	
	<u> </u>		8101 Connecticut A 5. Social Security Number 6. Sec			ast birthday)	If Under		hase	24 Hrs.	8 Date of Bin		ntgomen	J
	Funeral Director			M 2 <b>X</b> ]F	89	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, De October	y, Year) 15.	1914 Mar	thplace (State or Foreign ountry) ~v1and
	ס		Usual Residence of Decedent								0000001	10,	->	,
	nylan show	_	10a. State 10b. County			r, Town or Lo								10d. Inside City Limits
	Ba-f	Directo	Maryland Montgome	ry	Che	evy Ch								1 Yes 2 □ No
	nor 2 be no	듬	10e. Street and Number	11.0	.7.0		10f. Zip		.15				izen of What Co	
	s 23	eral	8101 Connecticut A	12. Was Decedent E		S 12.1	Mas Doss	208		nin? (Sno	acify Voc or No		ted Sta	
	her d	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		1			n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, Whit	
93	urs a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2∏ No	Specify:				Specify: W	nite
5-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f ehow than "natural", or Items 23a or 28a-f ehow healtest Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		16a. Deced	dent's Usua kind of wo	al Occupa	ition turing most	t of worki	na	16b. Ki	ind of Business	/Industry
2121	Athin ne.	du	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT u	se retired,						
2	filed w Hygiel other th		12 17. Father's Name (First, Middle, Last)			Нс	mema	ker	18 Mothe	r's Name	(First, Middle,		own Home	9
and	d be fully and of control of cont	Be C	Francis Grieb								Patzwe		Surrame)	
Maryland	should be tand Mental I amarked of umatic eve	은	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	g Address	(Street a					r Town, State, a	Zip Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if the 12 is marked other than "natural", or Items 23a or 28a-1 show item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Extension must be notified at		Jane Sim Dealy /Da	ughter		4800	Chevy	cha cha	se B1	Lvd.,	Chevy	Cha	se, Mar	yland 20815
Je,	s 1 a		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Name	ne of ther place	9) T.T.	anuar	y 23,	20c. Lo	cation - City or	Town, State
Ĕ	Pages nent of I ant: If ite		1 \( \overline{	emoval from State	4	of Hea	ven Ce	meter	y	200	4			, Maryland
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of once.		21. Signature of Funeral Service License		1305	Ro 75	, Name ar bert / 57 Wis	A Addres L. Pun Sconsi	s of Facility phrey n Aver	Funer	ral Home Bethesda,	/Beth Mar	nesda-Che yland 208	vy Chase, Inc. 314-3501
e			23a. Part 1/Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each lin	the death	. Do not ent	er the mod	le of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
( )	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute F	Rena1	. Failu	ıre							Onset and Death 2 Years
) is	/Medical Examiner		resulting in dealth)	Due to (or as a	a c <i>o</i> nsequ	ience of):								
		-	Sequentially list conditions,	Sepsis Due to (or as a	1 consequ	ianea uf):								
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o	an an rial-tr	Еха	resulting in death) Last	Due to (or as a	a consequ	ience of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ical		1.										
9	artifica ling pt e as tl	Physician/Med	IF FEMALE:								-	10	ı	
B0,	death certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal	death 3	Ectopic p					:	23d. Date of del Month	livery Day Year
P.O. Box	the a	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time or de	eatn 5∟	Other (sp	өспу)	_ <del>.</del>					
	uires that the dea	/ Ph	Part II. Other significant conditions con	tributing to death bu	at not resu	ilting in the ui	nderlying o	ause give	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
Records,	quires n sigr ald be	d by									101	res 2	X No 3□Pr	robably 4 DUnknown
Ö	s been si	olete									24a. Was		24b. Were au	utopsy findings available
æ	The lav	Completed				-					autop perfo 1  Yes	rmed?	death?	completion of cause of
ta	ian: rtifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
<u>&gt;</u>	Physician: r this certifica ral director, I	To	1 □ Yes 2 X No	lospital: 1   Inpatier		ER/Outpatien			4 [] 1401	rsing Hor	ne 5 🂢 Resid	dence (	5 □Other (Spe	city)
ū	ing P		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Y Ye <i>ar)</i>	28b. Time of Injury		8c. Injury Work			28d. Describe f	now injur	y occurred	
Sio	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	200 Bloom of Join	a. At ho		M		′es 2 □ 1		19f Location /f	Stroot on	d Mumbor or D	ural Bauta Numbar
Division of Vital	tal or Al	Certification;	4 Homicide determined	28e. Place of Inju building, etc	: (Specify	me, rarm, str	eet, tactor	/, опісе		-	City or Tov			ural Route Number,
	To the Hospital or Attending Physician: The I within 24 burs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 X Certifying Physical Check only 2 Medical Exeminates	sician: To the best of ner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred estigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier					. License					e signed (Mont	
1	5		*/Villa-fuy	ans				D233(	)8			Janu	ary 20	, 2004
			30. Name and address of person who co Victor Priego, M.I					, #4:	100,	Beth	esda, M	lary1	and 208	317
	Sta Registr	-	31. Date filed (Month, Day, Year)  JAN 28 200	32. Registra		ure &	Spo	relat	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 9:09 A M JAN. 25, 2004 KENNETH SHANNON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1**X** M 2□ F Yrs JULY 17, PA. 60 192-34-8910 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County 28a-f ahow Examiner must be notified at 1X Yes 2 □ No SILVER SPRING MONTGOMERY MD. Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 20906 U.S.A. 23a 11709 IDLEWOOD RD. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) lterns Pages 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify. þ WHITE 3 Widowed 4 Divorced Year or Dates: "natural" the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ELECTRONIC ENGINEER **ELECTRONICS** 5+ other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 shours Congramment of Heelth and Mental Hy Important: If item 27 is marked oth any injury or other treumatic aven once. 17. Father's Name (First, Middle, Last) Be JUANITA FITCH FRANK SHANNON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IDLEWOOD RD., SILVER SPRING, MD. 20906 FLORANCE J. PULLIAM/FRIEND 11709 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CHAMBERS CREMATORY JAN. 29,2004 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A -Chame 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARREST /Medical Due to (or as a consequence of) **Examiner** MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, should be 3 Probably 4X Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 1 Yes 2 XNo funeral director. 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D52261 JAN. 25, 2004 Item 23a) (Type, Print) 30. Name and address of person who completed cause of death HUGO CIR., SILVER SPRING, MD. 20906 **ALAN** R. SEGAL, M.D. 1517 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 30 JAN Registra

_			1 - For State Registrar	State of Maryland		rtment of F			giene Reg. No. 2	0 40	424
	Physici /Medi	cal		raham SELSKY					Day 25, 200	Year 04 4:0	ne of Death
7	Examir	ner	4a. Facility Name (If not institution, give stre Suburban Hospital			Bethes				gomery	
Ä	Funeral Director		5. Social Security Number  577-48-3039  Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthplace (Sta Country) New Jers	
	Maryland	tor	10a. State 10b. County Maryland Montgomer		N. Be	thesda		- , , ,			de City Limits Yes 2 XNo
	th with the 23e or 28s	Funeral Director	10e. Street and Number 11501 Huff Court			10f. Zip Code	20895		10g. Citizen of W United	,	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f ahow any injury or other traumatic avent, the Machael Examinar must be notified a once.	Ď	11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	opecify Yes or No- to Rican, etc.)	14. Race Black Specify:	- American Indian k, White, etc. white	n,
1215-0	rithin 72 hc ne. han "natur e Modical	Completed		on ompleted) College (1-4or 5+)	16a. Decede (Give k life. D	ent's Usual Occup and of work done of ONOT use retired	ation during most of wo	rking	16b. Kind of Bu	siness/Industry	
$_{A\mathcal{M}}$ Maryland 21215-0036	ild be filed v lental Hygie ked other ti ic avent, In	To Be Co	12 17. Father's Name (First, Middle, Last) Morris Selsky		Bro	oker	_	me (First, Middle,			
	ind 2 shou alth and M 27 is mar	<b>!-</b>	19a. Informant's Name/Relationship (Type, Gary Abramson, Nephe				and Number or Ri	Bethesda	r, City or Town, S	State, Zip Code)	
54:00 Baltimore,	Pages 1 and of He unt: If item		20a. Method of Disposition  1√2 Burial 2 ☐ Cremation 3 ☐ Rem  4 ☐ Donation 5 ☐ Other (Specify)	Over Holli State		ition (Name of atory or other place Memoria	- '	27/04		City or Town, State	
04: Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Ligensee		22. To 1	Name and Addres	ss of Facility	Funeral F	Jomo In	^	
	Physician /Medical Examiner		23a. Part 1. Soler the disease, or complicate shock, or heart failure. List only one complemediate Cause (Final disease or condition resulting in death)	ons that caused the death. euse on each line.  CoRENAL  Due to (or as a consequent	Y A	r the mode of dyin	DISEAS	or respiratory arm	est.	C 20012 Approxidinterval Onset a	
35/04	ecuted and -transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or irijury that initiated events resulting in death) Last	Due to (or as a consequen							
976			d	Due to (or as a consequer	100 01);					1	
) ( .0. Box 6	that the death certificate be led by the attending physicia detached for use as the bur	Physician/Medical	in the past 12 months?	If yes, outcome of pregnance    Unit of the second of the	ath 3 E	ctopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day	Year
LSK rds, P	es peq	by	Part II. Other significant conditions contrib	uting to death but not resulting	ng in the unc	derlying cause give	en in Part I.		pacco use contrib	oute to the cause of	of death?
SELS		Completed						24a. Was as autops perform	y prined? de	ere autopsy finding for to completion of sath? ☐ Yes 2 ☐ No	gs available of cause of
A M of Vital	Physicien: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hosp	ital: 1K Inpatient 2□ER	VOutpatient	3 DOA Othe		th (Check only one		(Specify)	
A H sion o	fter fier	Certification:	2 Accident investigation	(Month, Day Year)	Bb. Time of Injury			28d. Describe ho			
ABR Divi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certif	4 Homicide determined	8e. Place of Injury - At home building, etc. (Specify)				City or Town	, State)	or Rural Route N	umber,
and the same of th	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	Check only 2 Medical Examiner:	on: To the best of my knowle On the basis of examination and manner stated.	idge, death of and/or inve	stigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and mani ate and place, an	ner as stated. Id due to the cause	e(s)
	With To com	Σ	29b. Signature and title of certifier	lla		29c. License	number 52767	29	od. Date signed (01/25/	(Month, Day, Year П	)
		Dr.	30. Name and address of person who compl Harminder S. Sethi,			int)		1e MD	20852	·	
	Sta Registra	te	31. Date filed (Month, Day, Year)  IAN 2.8 2004	32. Registrar's Signature		Sporks			20072		

Usual Residence of Decedent    10a. State   10b. County   10c. City, Town or Location	Reg. No. 2
Physician Medical Examiner  1. Decedent's Name (First, Middle, Last)  RICKY W SCHMIDT  4a. Fecility Name (If not institution, give street and number)  2. Date of Month JANU  4a. Fecility Name (If not institution, give street and number)  2. SILVER SPRING  5. Social Security Number  2. 13 GLENALLEN AVENUE APT 202  SILVER SPRING  1. Director  8. Date of Month JANU  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  1. Director  2. Date of Month JANU  2. Date of Month JANU  4a. Fecility Name (If not institution, give street and number)  2. Date of Month JANU  2. Date of Month JANU  4b. City, Town, or Location of Death Interpretation of De	Death Day Year 3. Time of Death 7:00 A M  4c. County of Death MONTGOMERY  Birth Dey, Year) 9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits 1   Yes 2   No
Physician /Medical Examiner  RICKY W SCHMIDT  4a. Fecility Name (If not institution, give street and number)  4a. Fecility Name (If not institution, give street and number)  4a. Fecility Name (If not institution, give street and number)  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death JANU  4c. Fecility Name (If not institution, give street and number)  2213 GLENALLEN AVENUE APT 202  SILVER SPRING  5. Social Security Number  216-78-0960  Usual Residence of Decedent  10a. State  10b. County  MARYLAND  MONTGOMERY  SILVER SPRING  10c. City, Town or Location  MARYLAND  MONTGOMERY  SILVER SPRING  10c. Street and Number  2213 GLENALLEN AVENUE APT 202  20906  11. Marital Status  1 Never Married 2 Marned 5 County 10 Count	ARY 25, 2004 7:00 A  4c. County of Death  MONTGOMERY  3irth Dey, Year) 3, 1956 9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits 1   Yes 2   No
Examiner  4a. Fecility Name (If not institution, give street and number)  2213 GLENALLEN AVENUE APT 202  SILVER SPRING  5. Social Security Number  216-78-0960  Usual Residence of Decedent  10a. State  10b. County  MARYLAND  MONTGOMERY  11c. Was Decedent Ever in U.S.  Armed Forceg?  11c. Was Decedent ever in U.S.  11c. Never Married  3   Wirdowed 4   Divorced  11c. Security Number  2213 GLENALLEN AVENUE APT. 202  20906  11c. Size of Decedent Ever in U.S.  11c. Never Married  3   Wirdowed 4   Divorced  11c. Security Number  10c. City, Town or Location  10d. City, Town or Location  10d. City, Town or Location  10d. Size of Decedent  10d. Size of Decedent  10d. Size of Decedent  10d. Size of Decedent Ever in U.S.  11c. Never Married  3   Wirdowed 4   Divorced  11c. Security Number  10d. City, Town or Location  10d. City,	4c. County of Death  MONTGOMERY  3irth Dey, Year) 3, 1956  9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits 1   Yes 2   No
2213 GLENALLEN AVENUE APT 202  SILVER SPRING  5. Social Security Number 6. Sex 1 1 Months 1 Days 1 Under 1 Year 1 If Under 24 Hrs. 1 Months 1 Days 1 Hours 1 Min. 1 Months 2 Days 1 Hours 1 Min. 1 Months 2 Days 1 Hours	3. 1956  9. Birthplace (Stete or Foreign Country) MARYLAND  10d. Inside City Limits 1   Yes 2   No
Usual Residence of Decedent    10a. State   10b. County   10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country? USA
Usual Residence of Decedent    10a. State   10b. County   10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country? USA
10a. State 10b. County 10c. City, Town or Location  MARYLAND MONTGOMERY SILVER SPRING  10e. Street and Number 10e. Silver Spring 10f. Zip Code 2213 GLENALLEN AVENUE APT. 202 20906  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  SELF EMPLOYED  17. Father's Name (First, Middle, Last) URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print) MRS. KWANG SCHMIDT—WIFE 2213 GLENALLEN AVENUE SILVE  20a. Method of Disposition 220b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	1 □ Yes 2 No  10g. Citizen of What Country?  USA
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	10g. Citizen of What Country? USA
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	USA
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	No- 14. Race - American Indian, Black, White, etc.
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	Diddid Firming and
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	Specify: WHITE
Elementary/Secondary (0-12)  College (1-4or 5+)  SELF EMPLOYED  18. Mother's Name (First, Middle, Last)  URIAH SCHMIDT  19a. Informant's Name/Relationship (Type, Print)  MRS. KWANG SCHMIDT—WIFE  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Method of Disposition  Date  20c. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route N	16b. Kind of Business/Industry
To be described by the state of	Tob. Kind of Business industry
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	MUSICIAN
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	ARSON
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	
	20c. Location - City or Town, State
E o a z C	
Serial 2 Cremation 3 Removal from State GEORGE WASHINGTON CEM. 02/01/200  1 Signature Funeral Service Licensee 11800 NEW HAMPSHIRE AVE.	
GEORGE WASHINGTON CEM.02/01/200  1	
23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.	arrest, Approximate Interval Between
Immediate Cause (Final	Onset and Death 1 MONTH
/Medical resulting in death)  a. Due to (or as a consequence of):	T HONTH
Examiner Sequentially list conditions b.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Cause Disease or injury	
The standing to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
d	
IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 1 Live birth 2 Fetal death 1 Representations of death 2 Control of the respectful services and the services of the respectful services and the services of the respectful services and the services of the respectful services and the services of the respectful services and the services of the respectful services and the services of th	23d. Date of delivery
20	Month Day Year
the page of the pa	
	d tobacco use contribute to the cause of death?  ☐ Yes 21② No 3 ☐ Probably 4 ☐ Unknown
The law required to the la	- A
24a. W	as an 24b. Were autopsy findings available topsy prior to completion of cause of death?
	3 2ĒNo 1☐Yes 2☐No
24a. Was case referred to medical examiner?  1	1. 114
Thinpatient 2 Ervollipatient 3 DOA 4 Nursing nome 5th	esidence 6 Other (Specify) e how injury occurred
The state of the s	
27. Manner of Death 1	(Street and Number or Rural Route Number, Fown, State)
Log to the control of	
The state of the control of the cont	ne cause(s) and manner as stated.
and manner stated.  29b. Signature and title of certifier  29c. License number	e, gate and place, and due to the cause(s)
D35635	
30. Name and address of person who arm leted cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Day, Year)
JOSEPH KAPLAN, M.D. 1811 PRINCE PHILLIP DR. OLNEY, MD 20832	
State 31. Date filed (Month, Day, Year)  Registrar  32. Registrar's Signature  April 100 100 100 100 100 100 100 100 100 10	29d. Date signed (Month, Day, Year)

AID	AR SARA	CI	Please Type or Print in Black Indelibl		-	_	
			State of Maryland / Departmer 1 - State of Maryland / Departmer State of Maryland / Departmer State of Maryland / Departmer State of Maryland / Departmer Maryland / Departmer Certifical	nt of Health and M 3/04dhb fe of Death		ene . No. 2004	04245
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Haidar Saraci		January		20:25 M
	Examin			, Town, or Location of Death		4c. County of Deat	h
8			11919 Parklawn Drive T-2	Rockville	0. 0. 1/ 0.45	Monto	mery
3	Funeral		Months Months		8. Date of Birth (Month, Day, Y	(ear) 9. Birth	hplace (State or Foreign untry)
	Director	}	215-94-0975   TEM 2   7   24   Yrs.   Usual Residence of Decedent		may J, I	9/9 wasi	ington, D.C.
	/land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Man Lea	to	Maryland Montgomery Rockville				1 ☐ Yes 2 ☑ No
	h the	lrec	10e. Street and Number 10f. Zi	p Code	100	. Citizen of What Co	untry?
	th wil	Funeral Director	11919 Parklawn Drive, Apt. T-2	853	Į	Jnited Sta	ites
	ems erre	ner	Armed Forces?	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	or It	Y	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☑ Yes 1 ☑ Yes	2□ No Specify: Hond	uran	Specify: Wh	iite
21215-0036	72 hours after death with the Maryland natural; or Items 23s or 28s-f show alest Evantuet must be rediffed at	Completed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usu			b. Kind of Business/	
15	in 72	olet	(Specify only highest grade completed) (Give kind of w	ork done during most of work use retired)	ing		
212	with lene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter	's Apprentice		Constructi	.on
D	other.	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Surname)	
lar	Aenta Aenta rked ric ev	To B	Alex Saraci	Antonia	Aguilar		
Maryland	short and A sma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	s (Street and Number or Rura	al Route Number, (	City or Town, State, 2	Tip Code)
Σ	and 2 salth n 27 i			nerfield Lane			
ore	of H		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Nacemetery, crematory or Mont 1 g ome 1 y	other place) Febr		c. Location - City or	Town, State
Ë	tant:		'4 □Donation 5 □Other (Specify) / Crematorium,	Inc. $1, 2$	004 Be	thesda, M	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparation of Health and Mental Hygiene. Importanent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show enty injury go other treumatic event, Its Medical Exactions in all be notified at once.		21. Signature of Funeral Service Licenside Rockvi	nd Address of Facility Rob 11e, Inc. 300 kville, Maryl	ert A. Pi West Mor	imphrey Fu	neral Home/
	20200		M00689 Roc	kville, Maryl	and 20850	2805	Approximate
			23a. Fart1 Energy the hisease, or complications that caused the death. Do not enter the more than the fit silver. List only one cause on each line.	ue or cyrry, such as cardiac t	or respiratory arres		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Narcotic Intoxication				
	Examiner		Due to (or as a consequence of):				
45		er	Sequentially list conditions, b. Due to (or as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, it says leading to instructions.  But to (or as a consequence of):  Cause. Enter Underlying Cause (Disease or injury that initiated events  C.				
60,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
	icate be physicia s the bur	cal	d				
c 687	leath certificate I attending physi	Physician/Medic	IF FEMALE:				
Вох	death ce e attend ad for use	lan/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic			23d. Date of deli Month	ivery Day Year
0	0 0 0	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (s	:pecify)			
<u>α</u>	that the de ed by the detached	P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	ng pe	d by	Cocaine Use		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
COL	~ Q 70	Completed			24a. Was an	24b. Were au	topsy findings available
Re	The law ate has page 2 s	m d			autopsy	id?   death?	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	Ö	25. Was case referred to medical	26 Place of Deat	1 Yes 2 (Check only one)	No Yes	2 □ No
>		0 B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 D	Other	me 5 ☐ Residen	ce ŠXXOther (Spec	city) SCENE
Jou		n: T		28c. Injury at Work?	28d. Describe how	injury occurred	
io	Attending Property of the football of the funerable by the funerable of th	atlc	2 Accident Unknown "	1 ☐ Yes 2 🛣No	Found at ho	ome	
Division	r Atter de irecte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office	<ol> <li>Location (Stre City or Town,</li> </ol>	et and Number or Ru State)	ıral Route Number,
	urs af		11919 Parklawn Dr.		Rockville,		
	Hosp 24 hor Fune fely fi	edical	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)				
	To the Hospitei or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Med		9c. License number	290	I. Date signed (Monti	h, Day, Year)
	4(2)		Hoter . Com . Lalla	O.C.M.E.	1	anuary 27	•
	70		30_Name and address of person who completed cause of death (Item 23a) (Type, Print)				
				Street, Balt:	imore, Ma	ryland 21	201
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
-	Regist	rar	JAN 29 2004 Jenewa & Sp	racket			

		For 1 _ State	State	of Marylar		artment o			•	•	2001	01016
		Registrer  1. Decedent's Name (First, Middle)	n I ast)			lilicate	UI Deal	<i>u i</i>	2. Date of De	Reg. No.	LUUL	3. Time of Death
Physic	ian								Month	Day		
_/Medi		William Frankl 4a. Facility Name (If not institution				4b City To	wn, or Location	on of Doath	Januar		County of Deat	7:30 a.M.
Exami	ner				- 206		Elkton	on or Death		46.	Ceci	
		150 East Main 5. Social Security Number	Street, A	7. Age (In yrs.				der 24 Hrs.	8. Date of Bir	th		pplace (State or Foreign
Funeral Director		220-01-2789	1 <b>X</b> M 2□ F	91	Yrs.		Days Hour	s Min.	(Month, Da	y, Year)	. 1912 Co	Maryland
		Usual Residence of Decedent							, cccm.bc		, 1712	Train y maria
yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
Mar.	tor	Maryland C	ecil		E1kt	on						1X1Yes 2 □ No
h the	irec	10e. Street and Number				10f. Zip Co	ode			10g. Citi	zen of What Co	untry?
death with the Maryland ims 23e or 28e-f show Irrust be matthed at	Funeral Director	150 East Main	Street, A	partmen	t 206	21	1921			Uni	ted Stai	tes
deal	ner	11. Marital Status	12. Was De Amed I	cedent Ever in U	l.S. 13.	Was Deceden	t of Hispanic	Origin? (Special	ecify Yes or No Rican, etc.)	-	14. Race - Amer	
or ite		1 Never Married 2 Mar	ried 1 Tes	2 🔯 No	į.	1 ☐ Yes 2X	_		rican, etc.)		Black, White	hite
ours ours	dby	3 ☐ Widowed 4 💆 Divorced	Year or	Dates:		10103 24	a i to Speci	y.			Specify: W	nite
ING KIKIS SOOSO  be filed within 72 hours after death with the Marylan tial Hygiene. Independent than "natural", or items 23e or 28e-f show event, the Medical Examinat must be inclined at	Completed	15. Deceder (Specify only highe	it's Education st grade completed	1)	(Give	dent's Usual C	done durina m	nost of work	ing	16b. Ki	nd of Business/I	ndustry
in in in in in in in in in in in in in i	m	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use i						
FIG Z I Z I  e filed within al Hygiene. other than "		8	1		Cecil	County						ninistration
be file by oth	Be	17. Father's Name (First, Middle,							e (First, Middle,			
ACT YIGHT 2 should be and Mental 3 marked ( raumatic ev	2	Charles Robert					Ma:	ry Eli	zabeth	Whi	tehurst	
Darkim Ore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any njury or other traumatic enones.	1	19a. Informant's Name/Relations			11	ng Address ( $S$	Street and Nun 8550 Ca	mber or Rura amp Ro	al Route Number	er, City oi estei	Town, State, Z	ip Code) Maryland 21620
t and tealth		William Frankl 20a. Method of Disposition	in Shifle		/Son	sition (Name		7	Date			
ges Fort		1 X Burial 2 ☐ Cremation	3 Removal from	n State NO	rth Ea	matory or other	r place) h od i st	Janua	ry 31,	20c. Lo	cation - City or 1	Iown, State
LIM Pa tmen tant:		'4 □Donation 5 □Other (5			emeter	У		200	)4			, Maryland
DESILTINO  Permit. Pages Deportment of Important: If i any njury or once.	ì	21. Signature of Funeral Service	Licensee		1000	2. Name and A		. 01	ouch Fu			
		Marco U. E									ast, Ma <u>r</u>	yland 21901
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	t caused the deat each line.						rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	/	Mucca	cclial	Infar	ction					Onset and Death
/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):	1	. 5					- In Share
Lxammer		Immediate Cause (Final disease or condition resulting in death)  a. // Cearchal Infaction  Due to (or as a consequence of):  Alliano Sclorolic Heart Disease or injury  Due to (or as a consequence of):									un muz	
D #5	iner											
ecute and -trans	Examin	that initiated events resulting in death) Last	c									
( oU,	Ē	Due to (or as a consequence of):										
<b>a</b> 2.5	dicai		d									
wrequires that the death certificate been signed by the attending of should be detached for use as t	/Med	IF FEMALE:	220 H 100 6	uteama of aroon						F		
ath cer attendin for use	ian.	23b. Was decedent pregnant in the past 12 months?							2	3d. Date of delimination ::  Month	very Day Year	
thed it	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pre		leath 5L	Other (speci	rty)					
hat it bd by detac		Part II. Other significant conditi	ODS contributing to	death but not res	sulting in the u	nderking caus	se gwen in Da	ur I	23a Did t	nhacco u	se contribute to	the cause of death?
cords, wrequires t been signe should be	d by	Acetic	Anew		aning in the a	nconying caus	so givair iit i a					bably 4 Henknown
need hould	Completed	11000		<u>cqs</u> :							3110 0 0 1110	
has be seed to be seed to be seed to s	ig n								24a. Was autor	osv	prior to c	topsy findings available ompletion of cause of
VICAL MEC siclan: The law certificate has b lirector, page 2 s	S								1 ☐ Yes	rmed? 2 No	death?	2 🔁 No
VITAL iclan: T certificat ector, pa	Be	25. Was case referred to medica examiner?	Hospital:	·					(Check only o		0.110.000	
Phys rthis ral dir	၉	1 ☐ Yes 2 ☑ No	1 1	Inpatient 2	100000000000000000000000000000000000000		Other: 4				Other (Spec	ify)
ling ling l	on	27. Mannar of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day Year) Injury Work?										
VISION Attending ar death. ector: Atte by the fune	icat	2 Accident investi 3 Suicide 6 Could	not be			М	1 ☐ Yes 2	_				
or Al	Certification;	4 Homicide determ	aiond 286 Plac	ce of Injury - At h Iding, etc. <i>(Speci</i>	ome, tarm, sti fy)	eet, factory, or	iffice		City or Tov			ral Route Number,
pitel ours a prail		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifyii (Check only 2 Medicel	Exeminer: On the	basis of examina	ation and/or in	n occurred at t vestigation, in	my opinion, c	and place, a death occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
thin ithin in the complex	Me	29b. Signature and title of certifie	er and the	inner stated.		29c. L	icense numbe	er		29d Date	signed (Month	Day Year)
⊬≯ŕŏ		-	elicles	- C Min		λ	111192	2277		j	30.00	L
. 1		30. Name and address of person	who completed as	Use of death (the	m 22a) /Ti	Print)	0023	1726				
4		S. S. Sache	(P) MI)	118	Var	Z 57	See 6	33	EOR	En 1	MD219.	2/
St	ate	31. Date filed (Month, Day, Year,	32.	Registrar's Signa	ature							
Regist		JAN 3 0	2004	basis of examinationner stated.  - S MD use of death (Iter 11 8 Registrar's Signa	1 An	all .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** Day JANE VICKERS BROOKS SPRINKLE JANUARY /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10618 Perkins Hill Rd. Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 □ M 2 X F 18213-30-7049 Director Oct 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 23a or 28e-f show 10d. Inside City Limits direct rust be notified at **Funeral Director** MD 1 ☐ Yes 2 🔀 No Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10618 Perkins Hill Rd. death , 21620 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò Þ If Yes, Give Year or Dates: 1 ☐ Yes 2 No White 3X Widowed 4 ☐ Divorced Completed 7 is marked other than "natu traumatic event, the Macical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner-Operator Garden Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Philip Medford Brooks, Sr. Rose Eleanor Vickers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Jane S. Turner (daughter) 913 N. Meadowview Dr. Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 Donation 5 Other (Specify) Christ I.U. Cemetery 1/30/04 Worton, MD. 21. Signeture of Funeral Service License Galena Funeral Home of Stephen L Schaech M00510118 West Cross St. Galena, MD. 21635 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) iver o month /Medical Due to for as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examin The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed: 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Desidence 6 □ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: fospital or Attending P I hours after death. uneraf Director; After t Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ins. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Κ. Ross MD 516 Washington Ave. Chestertown, MD. 31. Date filed (Month, Day, Year) JAN 2 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

			1 For State	State of Ma		/ Depa	rtment of I	Health ar	· ·		е	01010	
			• Registrar			Cer	tificate of	Death		Rag. N	o. 2001	<u> </u>	
	Physici		Decedent's Name (First, Middle, Last)  EDNA STARKEY						Month	2. Date of Death Month Day Year JANUARY 29 2004 5:30a M			
p.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of			c. County of Deat		
	LXdiiiii	٠.	109 Main St.				Warwi	ck			Cecil		
	Funeral		Social Security Number     6. Security Number	ox 7. Age ⊒M 2027 F	(In yrs. las		If Under 1 Year Months Days		Min. (Month,	Day, Yea	9. Birt	hplace (State or Foreign	
	Director		219-44-1798 Usual Residence of Decedent		84	Yrs.			May 1	16 1	919 New	Jersey	
	how		10a. State 10b. County		•	Town or Lo						10d. Inside City Limits	
	Ba-1 s	cto	MD Cecil		War	wick						1 ☆Yes 2 No	
	with the or 2	Funeral Director	10e. Street and Number 109 Main St.				10f. Zip Code 21912				citizen of What Co	untry?	
	ns 23	eral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. V			n? (Specify Yes or		14. Race - Ame	rican Indian,	
စ္တ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Midical Exacting trauble multihad at ODGe.	y Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 N If Yes, Give		li li	Yes, specify Cut  ☐ Yes 2X No		n? (Specify Yes or Puerto Rican, etc.)		Black, White	e, etc. White	
Ö	hours tural',	d by	3X Widowed 4 □ Divorced	Year or Dates:						105			
Maryland 21215-0036	in 72 n "nat	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	lent's Usual Occu kind of work done OO NOT use retire	pation during most o	of working	160.	Kind of Business/	industry	
212	yiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)		omemak				Own Ho	me	
פַ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother	s Name (First, Mide	dle, Maide	n Sumame)		
<u>la</u>	Ments Ments arked atic e	<u>و</u>	Earl S. Starke	şγ				Mari	le Saatm	nan			
lar.	2 sho	1 7	19a. Informant's Name/Relationship (7	, ,						Route Number, City or Town, State, Zip Code)			
e)	1 and 1ealth sm 27 ther to		Wallace B. Sta	rkey (so	The state of the s		Box 8		CWiCk, M	-	ZI9IZ Location - City or	Town State	
פֿר	nt of the		1√2 Burial 2 ☐ Cremation 3 ☐	Removal from State			sition (Name of natory or other pla	ce)	2/2/04			le, MD.	
Baltimore,	artme artme ortant injury		*4 □ Donation 5 □ Other (Specify  21. Signal une of Figure 1 Service □ on		Ten		ille Co			_			
Ba	Deport Impo		000	M		0 11	8 West	Cross	s St. Ga	len	tephen a, MD.	L Schaech 21635	
			23a. Part Enter the disease, or comp shock, or hear failure. List only	olications that caused one cause on each lin	the death.	Do not ente	er the mode of dy	ng, such as ca	ardiac or respirator	y arrest,		Approximate Interval Between	
gr. "	Physician	1	Immediate Cause (Final disease or condition resulting in death)  a. EXI STAGE HOURT DISEASE  Due to (or as a consequence of):									Onset and Death	
	/Medical Examiner	b 1											
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events c.										
	uted d ansit	Examiner											
oʻ	te be executed ysician and te burial-transit	Exa	resulting in death) Last	Due to (or as a	a conseque	nce of):							
3760,		icai	d										
89 )	artifica ing ph e as t	Med	IF FEMALE:										
Вох	attend attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live birth	2 Fetel d	eath 3□	Ectopic pregnand	:y		13	23d. Date of deli Month	ivery Day Year	
o.	the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	tn 5L	Other (specify) _			-			
σ.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ing in the ur	nderlying cause g	ven in Part I.	23e. D	id tobacco	use contribute to	the cause of death?	
Vital Records,	en sig								11	Yes	2□No 3□Pr	obably 4 Unknown	
ဝင္ပ	S S S	piet							24a. W	tas an		topsy findings available completion of cause of	
Ě	The l	Completed							pe 1 □ Ye	nfórmed?	death?	2□No	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					of Death (Check on	ly one)		301323	
	Phys this al di	.T	1 Yes 2 No	1 ☐ Inpatie	1	R/Outpatien 8b. Time of	t 3□ DOA Ot 28c. Inju		sing Home 5 A		6 □Other (Spec	cify)	
Division of	Attending or death. ector: After by the fune	Certification:	Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wo	irk? ]Yes 2∐No		Je now in	ary occurred		
Visi	er dea rector by the	tifica	3 Suicide 6 Could not be 4 Homicide detainined	28e. Place of Inju	ury - At hom	e, farm, str	eet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
ō	urs aft rral Di			4					+1		·		
	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier  (Check only one)  12 Certifying Ph. 2 Medical Exam	ysician: To the best of liner: On the basis of and manner sta	of my knowle examination ted.	edge, death n and/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, and due to to occurred at the time	he cause( ne, date a	s) and manner as nd place, and due	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. D	ate signed (Month	n, Day, Year)	
			19/1/Del				1)5'	4073	>	20	JAN D'	4	
			30. Name and address are of who o	completed cause of de	eath (Item 2	(Type,		1	1 /		n- 100	7.0	
			Arles Tours, N 31. Date filed (Month, Day, Year)	32. Registra		RILLIM	auc C	a 1	YELLAST	) LE	DE 17/	10	
-	Sta Registi		JAN 3 0				Sports						

			1 - State Registraf/MFND ITEM #1 PER	tate of Marylar PhY G828 2/24	nd / D 1/04 J	epartment of F De <i>rtificate of</i> I	lealth Deati	and Mei h		ene g. No. 2006	01210	
	Physicia	an	Decedent's Name (First, Middle, Last)	MAE KINDALI		MPSON			Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	Mac Kendal  4a. Fecility Name (If not institution, give street		homp	4b. City, Town, or	s Looptio		anuary	7 25,2004 4c. County of Death	0620 M	
	Examin	er	Memorial Hospita			Easto		ii oi Deaui		Talbot		
	Funeral		Social Security Number	7. Age (In yrs.		day) If Under 1 Year	If Unde	er 24 Hrs. 8.	Date of Birth	1	place (State or Foreign	
	Director		216-22-8377	2 <b>X</b> ) F	81 Y	rs. Months Days	Hours	Min. Jt	(Month, Day, une 13,	1922 Mary	land	
100	and w		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	tv. Town	or Location					10d. Inside City Limits	
	f sho	or	Maryland Caroline		•	nton					1 X Yes 2 No	
	28a-	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of What Cour	ntry?	
	h with		301 S. Seventh Stree	t		21629				U.S.A.		
99	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heatth and Mental Hygiene. If the tit marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funerai	1 Never Married 2 Married	Nas Decedent Ever in U Armed Forces? IYes _ 2√_No f Yes, Give Year or Dates:	i.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic C an, Mexic Specif	an, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh:	etc.	
5	2 hou		15. Decedent's Education	on malatadi	16a. [	Decedent's Usual Occup	ation	ant of wardens	1	6b. Kind of Business/In	dustry	
7	ithin 7 18n °n 1 Med	Completed	(Specify only highest grade co	College (1-4or 5+)		life. DO NOT use retired	during mo	ost or working		Own Home		
7	ygien ygien her th		0		нош	emaker						
	uld be fit Mental H irked otl	ТоВе	17. Father's Name (First, Middle, Last) John	Kenda1			E11	. ,		aiden Sumame) Swope		
<u> </u>	2 sho and ? Is me		19a. Informant's Name/Relationship (Type,			Mailing Address (Street						
≥ 15	l and 1ealth im 27 her tr		Sassy Daniel/ Daught  20a. Method of Disposition		Additional transaction	South Seve	enth	Street	Contract of the last of the la			
5	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other ance.		1 Burial 2 □ Cremation 3 □ Remo	6 61-1	cemetery	, crematory or other place	(9)			Oc. Location - City or To		
	it. Pa rtmer rtant njury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Suneral Service Licensee		Cem	ncoln netery	ss of Fac	1/28/2		Brentwood, l vans Funera		
0	Department of the control of the con		1 Kall							MARYLAND		
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Onset and Death									
☆	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any locality 1 in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.									
	Physician: The law requires that the death certific this certificate has been signed by the attending prad director, page 2 should be detached for use as	Physician/Med	in the past 12 months?	f yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of o 9□Unknown	al death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1			23d. Date of delive Month	ery Day Year	
cords, r	quires that an signed b uld be deta	by								acco use contribute to the	ne cause of death?	
ם מפנים	sician: The law re certificate has be rector, page 2 sho	Completed	Caranany Antery Disperse							ed? prior to coi	psy findings available impletion of cause of	
A II G	lcian. Sertific ector.	Be	25. Was case referred to medical examiner?	ital:		Oth		ce of Death (C	heck only one	)		
5	Phys this rat dir	7	TO THE ZENE	1 Appatient 2 8a. Date of Injury	28h Tir		4 🗆 (	-		nce 6 Other (Specifi	0	
5	nding ith. :: After e fune	ation	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  1  Yes 2 No									
DIVISION	To the Hospital or Attending Physician: The la within 24 burus after death, within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)							I Route Number,		
	Hospita 24 hours 5 Funeral etely filled	edical C	29a. Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	owledge, ation and/	death occurred at the tim for investigation, in my of	ne, date a pinion, de	and place, and eath occurred a	due to the cau at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)	
	To th within To the	Me	29b. Signature and title of certifier	1/7		29c. License	e numbe	r	29	d. Date signed (Month,	Day, Year)	
			) ( ) or ( )o	Sho	Sol	00	05	3110		1/25/20	04	
			30. Name and address of person who complete Dennis Deshields. M						ton Ma	ryland 214	501	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 7 2004	32. Raistrar's Sign	ature	book	LUEL	, цаві	-v.1.9 P.d	y remu ZJ		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 22, 2004 **Physician** 9:30 Рм Thomas Spear Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 🕱 M 2 🗆 F Months Days 79 Yrs. April 17, 1924 Maryland 218-12-9811 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Worle Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.

Bant: If item 27 is marked other then "natural", or flema 23s or 28s-1 show ury or other traumatic event. The Medical Expirit part must be trainfied at Annapolis Anne Arundel Maryland 1 Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 U.S.A. 530 Wintersweet Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. | Types 2 □ No | Types 2 □ No | Year or Dates: 1943–46 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Howard Thompson, Jr. Edna Spear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page Anderson/daughter 530 Wintersweet Court Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 1/26/2004 Baltimore, MD \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Foneral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition day **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Phyaician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4\_Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Hinknown þ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? (exebrovas cular accedent 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient 2 ☐ ER/Outpatrent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ZNo this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in 24 hours after death.

In Funeral Director: A death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M) 00051437 01/24/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMC ANNAPOLIS, MD 21401 OKEDWO DARLY IBITUTE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 27, 2004 **Physician** 4:00 a M Margaret Ann Terenzoni /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Arnold 1008 Stonington Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Days Months Hours Min. **Funeral** 1 □ M 2 🛛 F 73 Washington, DC 16,1930 340-26-3913 Jun. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Example or must be notified at 1 ☐ Yes 2 No Arnold MD Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21012 USA 1008 Stonington Drive Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 💆 No Specify Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home irmit. Pages 1 and 2 should be fitted will apartment of Health and Mental Hygien. portant: If Item 27 is marked other this iy injury or other traumatic event, Item iy injury or other traumatic event, Item 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Boyce Richard Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1008 Stonington Drive, Arnold, MD 21012 Louis F. Terenzoni/Husband 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Feb. 2, 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Crownsville, MD Department of Important: If any injury or once. MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) permit. 22 Name and Address of Facility Barranco & Sons, 21. Signature of uneral Se Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEAVY teriosaleratic **Physician** /Medical Due to (or as a consequence of) Examiner PN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of): Due Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the use as 1 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month for in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed' 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check on one director Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 2 Yes 2 No (his funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending Injury 5 Pending investigation 1 ZNatural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) d address of person who completed 1/liAm 1117 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 30** 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25/2004 Month **Physician** TANKAM 1620 M ALVIN THOMAS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Bladensbus 5999 Emerson If Under 1 Year If Under 24 Hfs. 8. Date of Birth (Month, Day, Year) 37 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 M 2 □ F 215-32-1101 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r 28a-f show 1 No 2 No Bladensburg Prince Geo. Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If item 27 is marked other then "natural; or Items 23s or items ray or other traumatic event, the Medical Essinar marker.
Inty or other traumatic event, the Medical Essinar marker. 5999 Emerson Street 20710 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Baltimore, Maryland 21215-0036 55-61 Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stock Clerk Giant Food 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Smith George A. Thomas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6669 Seagull Ct., Frederick, MD 21703 Rhonda Belton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Nat'l Mem Pk 1/31/04 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Ligenses a testa 246 N. Wash. St., Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Athoroscherotic Cardiovascular Heart Diseas Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIASER 1 Yes 2 No 3 Probably 4 2 Unknown peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SALUMON vestor. AD 31. Date filed (Month, Day, Year)

JAN 28 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate	of .	Death			Reg. No.	2004	04251	* 2
	Physi	cian	Decedent's Nar	me (First, Middle, La	st)							2. Date of Dea	ath Day	Year	3. Time of Death	
-	/Med		Rebecca	Teitel								1	22	2004	9:10 am	
1	Exam	iner		(If not institution, giv					1	4b. City, To	wn, or Lo	cation of Death	4c. C	ounty of Deati	ר	
				Home Of G				If Under 1		Rockv If Under			Mon	itgomer		
	Funera		5. Social Security		M 2DF	Age (In yrs. la	st birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da		Co	nplace (State or Foreign untry)	1
	Directo	r	578-44-6 Usual Residence		X	89						<u>5-15-1</u>	914	Mich	igan	
	dand		10a. State	10b. County		10c. City,	Town or Loc	cation							10d. Inside City Limits	_
	Mary	ō	Md.	Montgome	rv	Chev	y Cha	se							1X Yes 2 ☐ No	
	r 28e	Director	10e. Street and Nu	umber				10f. Zip C	ode				10g. Citize	n of What Co	untry?	_
	ter death with the Marylan items 23a or 28e-f show iner must be notified at		4620 Nor	th Park A	v A			2081	5				USA			
	deat deat	Funerai	11. Marital Status	on rark n	12. Was Decede	nt Ever in U,S	. 13. V	Vas Deceder	nt of H	lispanic Ori	gin? (Spe	cify Yes or No	USA 14	. Raca - Amei		_
21215-0020	within 72 hours after death with the Maryland ana. than "natural", or items 23e or 28e-f show he Medical Examiner must be notified at	by Fu		ried 2 Married	Armed Force 1  Yes 21 If Yes, Give 4 Year or Date	Z) No		Yes, specify ☐ Yes 2		Specify:	i, Puerto	rican, etc.)	s	Black, White P <sup>ecify:</sup> Whi		
5-0	72 hc	Completed by	(Sne	15. Decedent's Ed			16a. Deced	ent's Usual (	Occup	ation	t of worki	na	16b. Kind	of Business/I	ndustry	
2	ithin	n je	Elementary/Sec		College (1-4	or 5+)	life. D	O NOT use	retired	d)		.9				
2		Ö	12				nous	e Wife	:					one		
and	0 0 0	Be	17. Father's Name	(First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Su	umame)		
3	should be nd Mantal marked o	2		m Faudem						Min	nie I	Jnknown				_
Maryland	2 8 8 8	1		lame/Relationship (	•	-						l Route Numbe			,	
	Haatth Hearth other tra		Gail Scl		aughter	20h Pla	10610 ce of Dispos	Rhode	Is of	sland	Ave.	#204 I		ville,	1d.20705	-
Baltimore,	nt of	0	1 X Burial 2	Determation 3		te Cei	netery, crem	atory or other	er plac		- 1/			•	own, otato	
뜶	it. Partur	. 9		5 DOther (Specification)		Juu	ean Me	Name and				23/04	01ne	y,Ma.		_
Ba	permit. Pages 1 and Dapartment of Haalth Important: if item 27 any injury or other t		21. Signature	divida Servica do	1	-						Direct	ion.	Inc.		
			20. 2.44 5/2	Jarry	1.15	N	109	1 Roc	kvi	11e F	Pike	Rockwill	I 1 a M	d. 208	52	_
			shock, or he	the disease for com art failure. List only	plications that caus one cause on eacl	sed the death. n line.	Do not ente	r the mode	of dyin	ig, such as	cardiac o	r respiratory ar	rest,	1	Approximate Interval Between Onset and Death	
	Physiciar /Medica		Immediate Cause	(Final			,		-	,				1	Onsot and Boats	
	Examine		disease or conditi resulting in death)	on	a. Cere				de-	.				1		_
		ē				Due to (or a	as a consequ	Jence of):						1		
	uted d ansit	Examiner	Consumption line of		b	Due to (or a	as a consequ	ience of):						1		-
oʻ	eath cartificate be axecuted attending physician and for usa as the bunal-transit	Ex	Sequentially list of if any, leading to it cause. Enter Und	mmediate erlying		200 10 (0. 1	20 4 00.1004	301100 017.						1		
68760,	te be yslcii	edicai	that initiated event	r injury	C	Due to (or a	is a consequ	ence of):								
39	ng ph ng ph nas ti	Med	resulting in death)	Lasi										1		
Вох	th ca tendi	ary			d											_
<u>.</u>	0 00	Physician	Part II. Other signi	ficant conditions o	ontributing to death	but not result	ing in the un	derlying cau	se giv	en in Part I.		23b. Did t	obacco us	a contributa	to the cause of death?	
P.O.	that the sed by the											1 🗆 1	fas 2□	No 3□Pro	bably 4 Unknown	n
ŝ	requires that been signed b hould be date	b												0.45 14		
5	w requires the been signed should be contact the conta	Completed										24a. Was a	an autopsy med?	a	Vere autopsy findings vailable prior to ompletion of cause	
ě	aw Is t	dr.													f death?	
=	The Bag											1u Y	38 2 P	No 1	☐Yes 2☐No	
<u>≅</u>	Physician: The rthis certificate rail director, pag	Be	25. Was case refe examiner?	/ †	Hospital:				Oth	/		(Check only o			10-1-10	9
Division of Vital Records,	Ø 0.0	. To	1 ☐ Yes 2 ☑ 27. Man r of Dea		1 ☐ Inpa		R/Outpatient 8b. Time of			4 C Nu		ne 5 🗆 Resid 28d. Describe h			ify)	=
o	E E	텵	1 Natural 2 ☐ Accident	5 Pending investigation	(Month, I	Day Year)	Injury	м	Injun Worl	k? Yes 2∐1			,			
ISI	Attending ir death. ector: After by the fune	fica	3 ☐ Suicide	6 Could not be		Injury - At hom	e, farm, stre	et, factory, c				8f. Location (S	treet and f	Vumber or Rui	ral Route Number,	-
Š	aftar Dire	Certification:	4  Homicide			etc. (Specify)						City or Tow	n, State)			
	To the Hospital or Attending Phwithin 24 hours aftar death.  To the Funeral Director: After this completaly filled in by the funeral		29a. Certifier	1 Certifying Ph	sician: To the be	st of my knowl	edge, death	occurred at	the tim	ne, date and	place, a	nd due to the o	ause(s) an	nd manner as	stated.	-
	he Hc in 24 he Fu pletal	edicai	(Check only one)	2 ☐ Medical Exam	and manner	of examinatio stated.	n and/or inv	estigation, in	my of	pinion, deat	h occurre	d at the time, o	date and pl	ace, and due	to the cause(s)	
	To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: A completaly filled in by the fu	Σ	29b. Signature and	title of certifier	. 1					e number				signed (Month		
	12	/	1 ta	y B W.	lle n	D .		D	55	258			Janua	nry LZ	200 3	
	•			res of person who		f death (Item 2	3a) (Type, F	rint)	,			y CAND		(		
				wilky, mo		MONTRO		D RG	Cle	nult	MAR	YLAND	200	352		
74	S Regis	tate trar	31. Date filèd (Mor	ith, Day, Year)  IAN 28 20	32. Regi	strar's Signatu	A A	Spa	16							

State of Maryland / Department of Health and Mental Hygiene

December Name Prints Manage Last   December Name					(	Certifica	te of	Death		Reg. No. 2	004	0425	5 5
Tournal Director  Tournal Dire			1. Decedent's Name (First, Middle, Last	n							Voor	3. Time of Death	i e
TOTO DO TO COMPANY  MATORY CATE PORTONIA  Social Seasons Number  1 Soci			Ora Pittman Tam	nney					_			2:00AM	
Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Seco	7		4a Facility Neme (If not institution, give	street and number)			4	tb. City, Town, or	Location of Deeth	4c. Count	y of Death		
The property of the property o			Manor Care-Potoma	ac				Potomac		Mon	tgomer	У	
TOO STATE DURING THE TOTAL CONTROL TO COMPANY AND THE STATE OF THE TOTAL CONTROL TO CONT	Т	Funeral			n yrs. last birth					th v. Year)	9. Birthpl	ace (State or Forei	ign
To State the Mary Hand Nontgonery Bethesda 107.2e Code		Director	723–18–9752	JW 5k1⊦	85 Y	rs.				, 1918	Nort	n Carolir	ıa
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please		2											
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please		arylar ahow	10a. State 10b. County	10	uc. City, Town	or Location					10		
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please		Se Maria		ry	Betheso								
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please		or 2	10e. Street and Number			10f. Z	ip Code			10g. Citizen of	What Count	.ry?	
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please		23e	5945 Avon Drive										
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please		and and and and and and and and and and	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Was Dec	edent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)				
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please	20	y F.		If Yes, Give		1 ☐ Yes	2☑ No	Specify:		Speci	ify:		
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please	8	d b									Whi		
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please	5	nath math			16a. I	Decedent's Us 'Give kind of w	ual Occup ork done o	ation during most of wor	rking	16b. Kind of I	Jusiness/Ind	ustry	
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please	12	A Para de	Elementary/Secondary (0-12)	College (1-4or 5+)						<b>NT</b>			
Abrams Martha Keel    19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name-Please Control   19a Informatic Name Please	2	Part the Co	17 Enthara Name (First Middle Leet)	<u> </u>	Ke	gister	ea Nu		no (First Middle				
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	Ĭ,	d out	17. Father's Name (First, Middle, Last)							Walden Suma	1110)		
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	<u>=</u>	Mer Mer Marke			1		(0)			O': T	0 7:		
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	Ma	l 2 st											
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	P, 1	f enc Health m 27 than t			20h Place of I	Dienosition /N	me of						
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	Ö	or of the state of	1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery	crematory or	other place	(8)			•		
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	ţ	Tien Pe			Mauso1	eum		1		Silver	Sprin	g, MD	
Physician // Carcinometric flexible in the details or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal.    Approximate shock or heart failure. List only one cause on each line.	39	emit eper npor ny in	21. Signature of Tuneral Service Licens	600		Bethes	ind Addres	ss of Facility Ko hevy Cha	bert A. se. Inc.	Pumphr (	ay Fun Wiscor	eral Hom	e/
Physician // Indicated Cause (Final Exercision of Part II. Other significant conditions contributing in death)  Part II. Other significant conditions contributing in death but not resulting in the underlying cause given in Part I.    Sale, Port II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardad or respiratory airest.   Approximate Interval Exercision (Architecture)		20 = 8 d	1 Smile to	eres. M	100803						. 15001		
Physician (Model)  Page 100 and 100 an		167	23a. Pert1. Enter the disease, or complishock, or heart failure. List only of	lications that caused the	e death. Do no	ot enter the mo	de of dyin	g, such as cardiad	or respiratory ar	rrest,		Approximate Interval Between	
The second of th		Physician									1	Onset and Death	
Due to (or as a consequence of):    Due to (or as a consequence of):			Immediate Cause (Final disease or condition	. Metas	stati	c En	dom	etrial	Carci	noma	44		
Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  C		ope <sup>2</sup> .	resulting in death)										
Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  C	-	ine si	-	h							ì		
Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  Cause (Disease or influty)  C		ecute and trens	Sequentially list conditions,	Du	e to (or as a co	risequence of	<u> </u>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribute to the cause of death   Part II.   Part II. Other significant conditions contribute to the cause of death   Part II.   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute	Ö,	Slan (	cause. Enter Underlying Cause (Disease or injury	•									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribute to the cause of death   Part II.   Part II. Other significant conditions contribute to the cause of death   Part II.   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute to the cause of death   Part II. Other significant conditions contribute	876	the the the the the the the the the the	that initiated events	Due	e to (or as a co	nsequence of)	:						
25. Was case referred to medical examiner?    Second   Se		ing p		d									
25. Was case referred to medical examiner?    Second   Se	30	th ce		0.									
25. Was case referred to medical examiner?    Second   Se		the e	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in I	the underlying	cause giv	en in Part I.	23b. Did 1	t <b>oba</b> cc <b>o us</b> e c	ontribute to	the cause of deat	h?
25. Was case referred to medical examiner?    Second   Se	Ρ.	d by 1							1 🗆 '	Yes 2□ No	3 🗆 Prob	ably 4 □ Unkno	wn
25. Was case referred to medical examiner?    Second   Se	Ś	es the igner igner be d									1		_
25. Was case referred to medical examiner?    Second   Se	ord	equir							24a. Was perfo	an autopsy rmed?	ava	ilable prior to	ŝ
25. Was case referred to medical examiner?    Second   Se	Ç	aw r 2 sh 2 sh									of d	eeth?	
25. Was case referred to medical examiner?    Second   Se	ď	The I							101	res 2 No	1 🗆	Yes 20M6	
Second Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of deat	ita							26. Place of Dea	ath (Check only o	ne)			
Second Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of death (Item 23a) (Type, Print)   Sunt Ica Process of person who completed cause of deat	<b>1</b>	ysici is ce direc		Hospital: 1 ☐ Inpatient	2 ☐ ER/Outp	oatient 3□ D	OA Oth	er: 4. Nursing H	lome 5 🗆 Resid	dence 6 ⊡Ot	her (Specify	)	
2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		g Ph erth neral		28a. Date of Injury (Month, Day Ye			28c. Injun Worl	y at k?	28d. Describe I	now injury occu	rred		
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suntificat Phoganilli, 1220A Eart Toppa Road Tocosa, Mary land 21266	ō	eth. eth. e fur e fur		(, 2, 2)	,								
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suntificat Phoganilli, 1220A Eart Toppa Road Tocosa, Mary land 21266	<u>Vis</u>	Atta er de ecto by th	determined	28e. Place of Injury	- At home, farr	n, street, facto	ry, office				ber or Rural	Route Number,	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suntificat Phoganilli, 1220A Eart Toppa Road Tocosa, Mary land 21266	Ö	s efter		January, etc. (c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					,,			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunit Ca Phogavilli, 1220A Earl Toppa Road, Tocosa, Mayland 21266		ospit hour ily fills		sician: To the best of m	y knowledge,	death occurred	at the tin	ne, date and place	, and due to the	cause(s) and m	anner as sta	ated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunit Ca Phogavilli, 1220A Earl Toppa Road, Tocosa, Mayland 21266		he H in 24 he Fi plete				or investigatio	, my o	PHILOII, CHAIN OCCU	neu at the time,	uate and place	, and ude to	a cau <b>s</b> e(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitan Phogavilli, 1220 A Earl Toppa Road, Tocosan, Maryland 21266		Z vith To t	29b. Signature and title of certifier		29d. Date sign	ed (Month, D	lay, Year)						
Sunita Phogarili, 1220A Eart Toppa Road Tocosa, May land 21266				//.			0)00			1124	104		
Sunita Magavilli, 1220A East Toppa Road, Tocosan, Maryland 21296		10		•					1				
AL DAMES IN A MANAGEMENT OF THE PARTY OF THE			Sunitera Bhogavil	li,1220A	East ]	Toppa	Roa	of TOC	es an.	May	land	21286	
State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  34. Registrar's Signature			31. Date filed (Month, Day, Year)			9 1	no V		•	•	·		

		- State Registrar Unpend Item#23a,27,28a-f,Per M	/ Department of Health and E <b>, இதர்<i>ij</i>வுக்கி</b> Death	Reg.	2001 010
Dhysisis		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of De
Physicia /Medica		WILLIAM T. TALLEY		JANUARY	22, 2004 0733 <i>I</i>
Examine	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
		1414 FAIRLAKES PLACE  5. Social Security Number 6. Sex 7. Age (In yrs. las	MITCHELLVILLE  t birthday) If Under 1 Year If Under 24 Hr		PRINCE GEORGES
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	Yrs. Months Days Hours Mir		9. Birthplace (State or F Country) 934 Maryland
-		Usuat Residence of Decedent		10 41 3,1	
show	_		own or Location		10d. Inside City I
8a-f	Director		ITCHELLVILLE		1 ☐ Yes 2
Lear		10e. Street and Number 1414 FAIRLAKES PLACE	10f. Zip Code 20721	10g.	Citizen of What Country?
ns 23 Irmst	erai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,
ial Hygiene. d other than "natural", or Itams 23a or 28a-f shov avent, the Medical Examinar mast be rediffed at	by Funerai	Armed Forces?  1 Never Married 2 Married  3 Widowed 1 Divorced  Armed Forces?  1 Yes, Give Year or Dates: 1952-1	If Yes, specify Cuban, Mexican, Pue	ento Rican, etc.)	Black, White, etc.  Specify: BLACK
ical E		15. Decedent's Education	16a. Decedent's Usual Occupation	166	o. Kind of Business/Industry
Man "	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	ranking	
Hygien Sther th ent, the	So.	2 yrs		NICIAN	WMATA
d oth	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid	,
	ို	WILLIAM H. TALLEY		ARA LUCKE	
f Health and Mer Item 27 Is marks other traumatic			19b. Mailing Address (Street and Number or F		
Health tem 27 other tra		Makiel T. Talley (Daughter  20a. Method of Disposition   20b. Plac	c) 4649 Wild Indi		, Houston, TX
do it of		1 Burial 2 Cremation 3 Removal from State	etery, crematory or other place)		
rtmer	-	'4 □ Donation 5 □ Other (Specify) iPet 1  21. Signature of Euperal Service Licensee	o Funeral Srv 1/2 22. Name and Address of Facility		lexandria, VA
Department of Healt Important: If Item 2 any injury or other ponce.		23a. Fart I. Enter the chease, or complications that caused the death.	246 N. Wash. St	E., Rockv	ille, MD 20850
	al Examiner	Immediate Cause (final disease or condition resulting in death)  Sequentially list conditions, if any, beauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Bypothermia with Due to (or as a consequence of the conditions).	ice of):	on	Onset and Dea
y the attending phy.	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ath 3 Sctopic pregnancy  h 5 Other (specify)	23e Did tobacc	23d. Date of delivery Month Day Yea
ig e	d by	at the end of the end	ig in the disconying eachs given at a att.	1 🗆 Yes	
been si	iete			24a. Was an	24b. Were autopsy findings ava
certificate has rector, page 2	e Completed	25. Was case referred to medical		autopsy performed	prior to completion of caus death?
this certific	00	examiner?	04	eath Check on v one	6 (State - 10 - 14 ) 3 (F) COT
⇒ o	- To		tb. Time of Injulyound 28c. Injury at Work?	28d. Describe how in	e 6 Nother (Specify) AT SCE
death. ctor: After y the funer	igo	1 Natural 5 Pending (Montocattear) 2 Accident investigation 1/22/04	7:00 a M 1 Yes 2 No	subject ex	posed to cold
to the	Certification	3 Suicide 6 Could not be 28e, Place of Injury - At home		28f. Location (Street	t and Number or Rural Route Number
2 9 6	ert	4 Homicide determined building, etc. (Specify)		City or Town, St 1414 Fairla	nkes Place, Mitchellvi
s after death	C 3		dge, death occurred at the time, date and place	ce, and due to the cause	e(s) and manner as stated.
124 hours after death.  Eunerel Director: After letely filled in by the fune	_	29a. Certifier (Check only one)  (Check only one)  (Check only one)	and/or investigation, in my opinion, death occ	curred at the time, date	and place, and one to the cause(s)
within 24 hours after o	Medicai C	(Check only 2 Medical Examiner: On the basis of examination	29c. License number		Date signed (Month, Day, Year)
within 24 hours after of To the Funerel Direct completely filled in by	_	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.		29d.	
within 24 hours after or  To the Funerel Direct  completely filled in by	_	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	29c. License number OCME	29d.	Date signed (Month, Day, Year)
	_	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier  39 Name and address of person who completed cause of death (Item 2)	29c. License number OCME	29d. JAI	Date signed (Month, Day, Year) NUARY 22, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** January 26, 9:17 A M 2004 Robert T. Tabb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director Dec. 1, 1953 Washington, D.C. 215-66-6601 50 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any jury or other traumatic event, If a Medical Examinst must be notified at once. 10b. County 1 ☐ Yes 2 No Directo Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 Samplers Way 20854 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 XX Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Printing Sales 4 Sales Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rolland Tabb Betty Tydings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. Tabb/Wife 1003 Samplers Way, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of
Heaven Cemetery January 30, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01346 Approximate Interval Between Owet and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause in each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** 12 " Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes or Attending Physician: 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 R/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) ≥8b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of ception 2 30. Name and address of person who completed cause of death (Item 22a) (Type, Print) William Dooley, M.D. 9901 Rockville, MD 20850 Medical Center Drive. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 29 2004 24200 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			100	1- State Amend Item#25perPHYG828 2	/27/04 EWC	Certificate of		Reg. I	200	0425
	П	Physici	an	1. Decedent's Name (First, Middle, Last)			Mor		Day Year	
		/Medic		PAUL DOUGLAS TAYMAN Jr  4a. Facility Name (If not institution, give street and number)		4h City Town	JAN or Location of Death	UARY	25,200 4c. County of De	
		Examir	ıer		D			1		
	2.	Funeral			(In yrs. last birtho		If Under 24 Hrs. 8, Date	of Birth	CHARI 9. B	ES inthplace (State or Foreign Country)
		Director		214-28-4209 1 <sup>1</sup> / <sub>X</sub> M <sup>2</sup> F	71 Yr	s. Months Days		24 19		ryland
	2	2 >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o					
$\geq$	6	sho	2	Maryland Prince George's		dywine				10d. Inside City Limits 1 ☐ Yes 2 🗓 No
AM	A of	or 28a-1 show	ecto	10e. Street and Number				10: 6	Citizen of What C	
_	dia	MILE OF THE	Ö	10505 Cedarville Road Lot 3	14	10f. Zip Code	20613	Tog. C	USA	country?
2	death	ours after death with the Maryland rai', or Items 23a or 28a-f show Examinat must be notified at	Funeral Director	11. Marital Status 12. Was Decedent E				or No-	14. Race - Am	encan Indian.
>	à	or Items	Fun	Armed Forces? 1 □ Never Married 2 Marned 1 □ Yes 2 No.	0		dispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e	(c.)	Black, Wh	ite, etc.
+	5-0036	rair, o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 212 No	Specify:		Specify: W	hite
12	ָה ה	natural',	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occup	pation during most of working	1 <b>6</b> b.	Kind of Busines	s/Industry
		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Ig II	Elementary/Secondary (0-12) College (1-4or 5+		fe. DO NOT use retire: ineer	during most of working d)	Na	rcing U	ome Care
	ביים ביים	Hed v		12 17. Father's Name (First, Middle, Last)	Ling	THEET	18. Mother's Name (First, I			One care
1	and and	od of	Be	Paul D. Tayman Sr			Nora Lawson			
$\sim$	Maryland 42 should be fit	nark mark	ပ္	19a. Informant's Name/Relationship (Type, Print)	19h M	failing Address /Street	and Number or Rural Route			Zin Code)
2	Z Z	Ithar 11thar 27 is rtrau		Mary C. Tayman (wife)			lle Rd Brandy			
P	ā, -	f Hea item othe		20a. Method of Disposition	20b. Place of D	isposition (Name of	Date	20c.	Location - City o	r Town, State
7	e a	rage lent o nt: If ry or		1 XBuria 2 Cremation 3 Removal from State , 4 Dornation 5 Other (Specify)	Trinity	Memorial G	ardens 1-30-	04 Wa	ldorf,	MD
	Saltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Ma once.		21. Signature of Fineral Service Licensee MOO.		22. Name and Addre	on of English	in Fun	eral Se	razione
1	n a	Depa Impo		Smith Chew	1/3	4433 White	e Pls. La. Wh			
		8 5		23a Part . Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	the death. Do not	enter the mode of dyir	ng, such as cardiac or respira	tory arrest,		Approximate Interval Between
	P	hysician		Immediate Cause (Final disease or condition	entory	fail	ure			Onset and Death
		/Medical Examiner		Due to (or as a	consequence of)					
		.xammer	_	Sequentially liet outditions, b Se	PTLC	SHOCK				
	pe	asit eu	Examiner	Esquantially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	onsequence of):	0 00	hp. 5-2			
	D&/DU,	sicien and burial-transit	xan	triat initiated events	c sequence of):	10 recox	hemore	4		
	D&/DU,	sicier buris		Cel	9aul	7 My		V		
Ġ	O O	ng physi as the t	Aedical	-	7	6				
	DOX	attending for use	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of		205			23d. Date of de	slivery
10	deat u	the atte	icia	in the past 12 months?  1 Yes 2 No  1 Live birth 2 4 Pregnant at ti		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	·		Month	Day Year
2	֓֞֞֞֝֞֞֞֞֝֞֜֞֞֞֞֞֜֞֞֞֞֞֞֞֞֞֞֞֞֝֞֞֞֞֞֝֞֞֞֞֝֞֝֞֡֝֞֝֞֡֝֞֝֞֡֝	by the	Physician/A	9 Unknown						
#	ords, F.O. Box	pe de	by	Part II. Other significant conditions contributing to death but	not resulting in th	e underlying cause giv	d 4 31			o the cause of death?
	VICAL RECORD	phoned should	Completed by	mon mesale before	rour -	17/0 26.03	mellion	1 ☐ Yes 2	2 □ No 3 □ P	robably 4 Onknown
		2 2 2	npie	COTOMATY Arbery	Orse	rosl		Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
-		ate pag		COLOMBE Deley	BYNDE	2 Cars	10	performed? Yes 22N	death?	2 □ No
2	OI VICE Physician:	certifi	Be	25. Was case referred to medical examiner?  1. Type 2. Who		Oth	26. Place of Death (Check			
		r this ral din	. To	1 ☐ Yes 2 💢 No Pospital: 1 Anpatient 27. Manner → Death 28a. Date of Injury			4   Nursing Home 5	Residence cribe how inju		ecify)
20		th. After tuner	tion	1 Natural 5 Pending (Month, Day	Year) Inju	ry Worl	/ 280. Des k? Yes 2 □ No	ande now inju	ary occurred	
7	OIVISION	r dea	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur	y - At home, farm,	street, factory, office	28f. Loca	ion (Street a	and Number or R	ural Route Number,
$\cup$ $\ddot{z}$	2 9	s afte s afte ad in t	Certification;	4 ☐ Homicide determined building, etc.	(Specify)		City	or Town, Stat	te)	
	Hospital or	hour hour ly fille	cal (	29a. Certifying Physician: To the best of	my knowledge, d	eath occurred at the tin	ne, date and place, and due t	the cause(	s) and manner as	s stated.
			Medical	one)   madical examinar; On the basis of e	examination and/o	r investigation, in my of	pinion, death occurred at the	time, date ar	nd place, and due	e to the cause(s)
	0	To the comple	Σ	29b. Signature and title of certifier	u .	29c. License	e number	29d. Da	ate signed (Mont	h, Day, Year)
				Same & Wille	_ N		0026262	1	26/00	+
		1.1		30. Name and address of perso / w o completed cause of dea	ath (Item 23a) (Typ	pe, Print)				

State Registrar SAMUEL J. KLEIMAN 11711 ITVINGSTON RD, TOU FT, WASH, MD, 20744

			1 - For State Registrar	State of I	Marylan		artment rtificate			and Me		giene eg. No. 200	-	042	259
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle Anilee Ruth To 4a. Facility Name (If not institution	aylor	er)		4b. City, To	own, or	Location o	,	Date of Dea Month	Day Y		3. Time of 20:45	
	Funeral Director	e.	Chester River 5. Social Security Number 440-20-7259	Hospital C		-	If Under 1		It Under the Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day	Kei Year) 9 , 1922 (	Birthpla Count	ace (State or ry) ahoma	Foreign
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 te marked other than "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Exam har match the notified at	al Director	Usual Residence of Decedent   10a. State	<u>Kent</u>	10c. City	Ches	tertow 10f. Zip C	Code	1620			10g. Citizen of Wha	it Count	d. Inside Cit 1 X Yes	
-0036	hours after deel	ed by Funeral	11. Marital Status  1 Never Married 2 Marr 3 XWidowed 4 Divorced	If Yes, Give Year or Date	ss? XNo	16a. Dece	1 ☐ Yes 2[	XNo Occupa	Specify:		fy Yes or No- can, etc.)	14. Race-Black, Specify:	White, e	te.	
ind 21215-0036	be filed within 72 tal Hygiene. d other than "ne	Be Completed	(Specify only highes Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-4-3) Last)	or 5+)	life.	kind of work DO NOT use OOkkee	per				Farm Equi Dealershi Maiden Sumame)		nt	
e, Maryland	1 and 2 should be Health and Mental Iem 27 Ie marked o sther traumatic eve	<b>T</b>	Samuel H. Tu  19a. Informant's Name/Relations  Lauralea Taylor  20a. Method of Disposition	nip (Type, Print)	20h P		vford !	Cour	nd Numbe		Route Number	r, City or Town, Sta	21	620	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		1 Gurial 2 Cremation 4 Donation 5 Other (S)	pecify)	ate G	emetery, crei nkawa1	Cemet	er place ery Address	1 s ot Facilit	/30/2	004	Tonkawal, am Funera , marylar	Oa!	klahor	
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. a.	sed the death	n. Do not ent	30_Spe ter the mode	er h	oad (	Chest cardiac or	ertown respiratory arr	, marylar <sub>est,</sub>		1620 Approximate Interval Betw Onset and D	reen I
3760,	cate be executed physicien and sthe burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or	as a consequ	uence of).									
.O. Box 68	The taw requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ∏Fetal tat time of de	death 3	Ectopic pred					23d. Date o Month		•	ear
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to deat	Also.	ulting in the u	nderlying cau	use give	n in Part I.		1 □ Y		Proba	bly 4 □U	nknown
Vital Rec	ician: The law certificate has t rector, page 2 s	Be Completed	25. Was cast referred to medical examiner?	la trus	W (A)	hetos		M. F.		of Death (	24a. Was a autops perform Yes	sy prio med? dea 2 No 1	r to com th?	sy findings a pletion of ca	use of
Division of V	ding Phys I. After this funeral dir	Certification: To	1   Yes 2   No  27 Manner of Death 1 Natural 5   Pendin 2   Accident investig	gation		ER/Outpatier 28b. Time o Injury		c. Injury Work	4   140	28		ence 6 Other (	Specify)		
DİXİ	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical Certific	4 Homicide determ	ined 286. Place of	, etc. (Specif) est of my kno	v) wledge, deat	h occurred at	t the time	e, date an	d place, an	City or Town	ause(s) and manne	er as sta	ited.	
	To the Hospitel within 24 hours To the Funerel completely filled	Medi	29b. Signature and title of certifie	and manner				License	number	186	2	t9d. Date signer (A		,	
	Sta Registr		30. Name and address of person Dr. Wayne Ben 31. Date tiled (Month, Day, Year)	jamin, M.D	1	Churc		l Ro	ad, (	Cheste	ertown,	, Marylan	d 21	620	

			For Stete Registrar	State	of Marylan	-	artment of H		and Mer		giene Reg. No.	200	4 04260
			Decedent's Name (First, Midd.	le, Last)						Date of Dea	ith		3. Time of Death
	Physici		Eunice Win	ifred	Under	wood			1 _	Month anuar	Day y 22		1:15 <sup>P™</sup>
1	/Medio		4a. Facility Name (If not institutio		um <i>ber)</i>		4b. City, Town, or	Location o		undar		County of Dea	
	LAdilli	C1	Manor Care - W	heaton			Silver S	prine			l M	lontgom	erv
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days			Date of Birth (Month, Day		9. Bir	thplace (State or Foreign ountry)
	Director		214-48-5934	1□M 2ਊF	89 .	Yrs.	Months Days	nouis	Ma	r 26,	191	4 SD	Julia y
	p ,		Usual Residence of Decedent  10a. State 10b. County		100 Cib	y, Town or Lo	antion						10d. Inside City Limits
	aryla	'n											1 ☐ Yes 2 ☑ No
	8e-1	Director	MD Montg	omery	S1.	lver S					10= Citi	zen of What C	
	with ti	Dir	10e. Street and Number				10f. Zip Code					ZOTI DI VVIIAL CI	outility?
	ilied within 72 hours after death with the Maryland Hygiene. kher than "natural", or items 23a or 28e-f ahow kher than "matural", or items 23a or 28e-f ahow ant, it a Medical Examener vust be molfilled at	Funeral	10302 Ridgemo		cedent Ever in U.	S 12	20901	ienanie Ori	nin? (Specify		USA	14. Race - Ame	erican Indian
	Rem Rem	nu.	11. Maritat Status  1 □ Never Married 2 □ Mar	Armed F	Forces?	.3.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican	, Puerto Rica	an, etc.)		Black, Whi	
5	rs aff	by F	3 ☑ Widowed 4 □ Divorced	tf Yes. G	ive		1 □ Yes 2 🖺 No	Specify:			-	Specify: W	hite
215-0036	2 hou	ed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occupa	ation			16b. Kir	nd of Business	
ر د	nin 72 n "nu Metall	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of work done a DO NOT use retired,	<i>during</i> mosi ()	t of working				
	d with	E	12	Conego	(1-40/ 5+)	Secre	tary				C1	erical	
9	0 - 0 5	Bec	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (F	irst, Middle.	Maiden	Sumame)	
<u>a</u>	Aental Aental rked o	To E	Frank Calhoon					Mary	Moore	2			
Maryland	and N s me		19a, Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	or or Rural Ro	oute Numbe	r, City or	Town, State,	Zip Code)
	and 2		Karen States /	Daughter	•	58 C	lark Ct.,	Wood	land,	CA 95	776		
e e	es 1 and 2 should to of Health and Ment of Item 27 is marked y other traumatics		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation	2 Demonal from		Place of Dispo emetery, crei	sition (Name of matory or other place	θ)	Date		20c. Lo	cation - City or	Town, State
Ĕ	Page Int: H		1 ☐ Burial 2 ESCremation 4 ☐ Donation 5 ☐ Other (5		Met	ropolit	an Cremato	$\operatorname{ry} \mid$	Jan 24 <b>,</b>	2004	Ale	xandri	a, VA
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service	Licensee	4		2. Name and Addres						ral Home, Inc.
			23a. Part1. Enter the direase, p shock, or heart failure. Lis	complications that	caused the death								Approximate Interval Between
¥	Physician		tmmediate Cause (Final										Onset and Death
Į.	/Medical		disease or condition resulting in death)		eimer's		se						14 years
	Examiner						Cardiovas	cular	Dises	926			vears
	- P	Jer	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a conseq	uence of):	bararovas	culai	PIBCC	<i>1</i> 50			years
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	🥤 в Нуре	rtension	n							years
o,	ate be executed hysicien and the burial-transit		resulting in death) Last		o (or as a consequ								
/60,	te be ysicie	cal		d. Hype	rlipemia	<b>a</b>							years
ĝ	tifica ng ph as th	g	15.555								-		
ŏ	death certificate e attending phys d for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Feta		Ectopic pregnancy				2	3d. Date of de	
ם מ	deal	300	in the past 12 months? 1 ☐ Yes 2 🙀 No		gnant at time of de		Other (specify)					Month	Day Year
5	n requires that the de been signed by the should be detached	hy	9 Unknown	-				-			_		
Ś	requires that been signed b hould be deta	by F	Part II. Other significant conditi	ons contributing to	death but not resi	ulting in the u	nderlying cause give	en in Part I.					o the cause of death?
Cord	equir en si ould								_ 3	1 U Y	es 21	UNO 3LIP	robably 4 Unknown
ပ္ပ	as be	ple								24a. Was a		24b. Were at	utopsy findings available completion of cause of
Ÿ	0 - 0	Completed								perfor	med?	death?	2 □ No
<u>Z</u>	ician: Th certificate rector, pag	BeC	25. Was case referred to medica examiner?	ıl				26. Place	of Death (C				
	S S	ToE	1 ☐ Yes 2 🔀 No	Hospital: 1 □	tnpatient 2	ER/Outpatier	nt 3 DOA Othe	er: 4 🔯 Nu	rsing Home	5 🗆 Resid	ence 6	Other (Spe	ocify)
0	ng Ph ter th neral		27. Manner of Death 1 ⊠Naturat 5 □ Pendi	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d	Describe h	ow injury	occurred	
<u>0</u>	Attending r death. •ctor: After by the fune	atle	2 Accident invest	igation			M 1 🗆 Y	Yes 2□I	No				
UIVISION	- 9	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningd 200. Flat	ce of tnjury - At ho ding, etc. (Specif	ome, farm, str y)	eet, factory, office		28f.	Location (S City or Town			ural Route Number,
_	urs al		20 0.45.	- Division Table		4-4 4-4			4 4 4 4 4 4 4 4	1	(.)		<u> </u>
	To the Hospital of within 24 hours affine To the Funerel Discompletely filled in	edical		ng Physician: To the Examiner: On the and ma									
	Fo th within Fo th	Me	29b. Signature and title of certific	ər			29c. License	number		2	29d. Date	signed (Mont	th, Day, Year)
	12		MSBit	The TOTAL			D 17729	9			1/	23/2004	4
	V		30. Name and address of person		use of death (ttem	п 23а) (Туре,	Print)						
			George B. Patr	ick, III	M.D. 92	221 Co	lesville 1	Road,	Silve	r Spr	ing.	MD 209	910
	Sta		31. Date filed (Month, Day, Year	32.	Registrar's Signa	ture /							
	Registr	ar	JAN 2	8 2004	Serva	100	1						

				State of	Marylar		epartme Certific			nd Menta		ene 0	Control of the contro	043	261
			1. Decedent's Name (First, Middle, Las.	t)						2. Dat	of Death		Y	3. Time o	f Death
	Physici /Medio		MICHAEL	JAME	ES		VERD	IIN				Day 20(	Year	8 - 3	0 am
À	Examin		4a Facility Name (If not institution, give	street and numb	ber)		1 11111	4	4b. City, Town	, or Location o		4c. County			O am
Ä.			PRINCE GEORGES	HOSPI	TAL	CENT	ER		CHEVE	ERLY		PRINC	CE GE	ORGE	' C
	Funeral		5. Social Security Number 6. Se		. Age (In yrs.	last birth	day) If Un Monti	der 1 Year	If Under 24 Hours	Hrs. 8. Date Min. (Mo	of Birth	Year) L 9 5 2	9. Birthpl Count	ace (State	o <i>r Foreig</i> n
ш	Director		134 00 0733	3M 2UF		51 Y	rs.			12-	20-1	1952	TEXA	Ŝ	
	pug ≱_	}	Usual Residence of Decedent  10a. State 10b. County		10c. C	itv. Town	or Location			<del></del>			10	d. Inside C	ity Limits
	/anyla	ō	MD Prince G	George		-		TED							2 □ No
	28a-	ect	10e. Street and Number			MI.	RAIN	Zip Code			10	g. Citizen of	What Count	rv?	
	Sa or	٥	3320 BUCHANAN	STREE	ст. #	301		2071	2			U.S.			
	Heath His 2%	era	11. Marital Status	12. Was Deced	ent Ever in U		13. Was Da	cedent of H	ispanic Origin	? (Specify Ye	s or No-	14. Rac	e - America		
21215-0020	Demit. Pages I and 2 should be filed within 72 hours efter death with the Maryland Depkinnent of Health and Mental Hyglene. Depkinnent of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show any highest if item 27 is marked other than "natural", or items 23a or 28a-f show any highest or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	X No			pecify Cuba s 2□XNo		Puèrto Rican, e	tc.)		ck, White, e y: BLA(		
ŏ	2 hou	De le	15. Decedent's Edu			16a. C	ecedent's U	sual Occup	ation	f	1	6b. Kind of B	usiness/Ind	ustry	
2	hin 7	be	(Specify only highest grad Elementary/Secondary (0-12)	(1-4 Completed)	or 5+)	- 9	life. DO NO	work aone i Tuse retired	during most o	r working					
7	giene	Š	1 2			-	ruck	DRI	VER			PR	IVATI	Ξ	
b	al Hy loth	Be Completed	17. Father's Name (First, Middle, Last)						18. Mother's	Name (First,	Middle, M				
Maryland	Ment Ment arked	2	LAWRENCE	VE	RDUN				ROS	E		SING	LETOI	1	
Jar	2 sho		19a. Informant's Name/Relationship (7)		D D					or Rural Route					O MD
dî	and lealth m 27 her to		LUCILLE VERDU	N - WI			Disposition (		NAN 5	TREET,					, MD
Baltimore,	if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		ate	cemetery,	crematory o	or other place	•	01-2	1	oc.Location - Rivero			
≣	rtmer rtant njury	+	4 Donation 5 Other (Specify)		Ri	verd	lale		ss of Facility	200	4	FUNE			
Ba	e die		21. Signature of Funeral Service Licens	001					•						
9	X	$\rightarrow$	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	(WXII)						PITOL				OC 20 Approximat	
1	Physician /Medical Examiner	ler		a	-i V 1	1-72 or as e co	nsequence	FH'					1	Onset and	Death
	uted d ansit	直	Conventionly list conditions	b			nsequence						1		
o,	an en riel-tr	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				LLOP								
68760,	ficate be executed physician end is the bunel-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			nsequence of		*						
~			resulting in death) East		(-7V1	1-72	11176	0 12	174						
Box	death certifica e attending ph ed for use as t	lan/		o											
	0 0 7	sic	Part II. Other significant conditions con	ntributing to deat	h but not res	ulting in t	he underlyin	g cause giv	en in Part I.	23	. Did tob	acco usa co	ntributa to	tha causa	of death?
9. O	res that the designed by the a	by Physician/M									1 🗆 Yas	s 2 No	3 ☐ Prob	ably 4□	Unknown
Vital Records,	requir	Completed by								248	. Was an	autopsy ed?	avai	e autopsy t lable prior t pletion of d eath?	to _
ž	ysician: The law his certificate has t i director, page 2 s	Ë									1 ☐ Yes	2 X No	1 🗆	Yes 2□	No
<u>ra</u>			25. Was case referred to medical						26. Place of	Death (Check	only one	)	l		
<u>&gt;</u>	Physica this ce	P	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2	ER/Outp	atient 3	DOA Othe	er: 4 🗆 Nursi	ng Home 5	Residen	ce 6 □Oth	er (Specify)		
ion of	Attending Physician: In deeth. ector: After this certific by the funeral director.		27. Manner of Death  1 Natural 5 □ Pending 2 Naccident investigation	28a. Date of (Month,	Injury Day Year)	28b. Tin Inji		28c. Injun Worl	∕at ∢? Yes 2∐No		cribe hov	v injury occur	red		
DIVISION	To the Hospital or Attending PP within 24 hours after deeth. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	Injury - At h , etc. (Specil	ome, farm	n, street, fact	ory, office			ation (Stre or Town,	eet and Numb State)	er or Rural	Route Num	ber,
	e Hoepit 24 hour e Funere	edical	29a. Certifier (Check only one) Cartifying Physical Example	sician: To the be nar: On the basi and manner	s of examina	wledge, o	leath occurre or investigati	ed at the tim on, in my op	e, date and p pinion, death o	lace, and due occurred at the	to the cau time, dat	use(s) and ma e and place,	inner as sta and due to i	ted. he cause(s	;)
	To the within To the To the To the To the Toomp		29b. Signature and title of certifier	/			:	29c. License	number		290	d. Date signer	d (Month, D	ay, Yeer)	
	n		19e	he				1)00	2537	03		1/2	3/0	04	
	(2)		30. Name and address of person who co	ompleted cause of	of death (Iten	n 23a) (Ty 0/ H	pe, Print)	L DK	?	CHE	VERL	y M)	) &	0185	
	Stat Registra	G	31. Date filed (Month, Day, Year)	_	istrar's Signa	ature	ha	who)				/			

			1 - For State Registrar	State of N	Marylan	id / Depa	artment rtificate	of H	ealth a	and M		giene 2	Carry Carry	042	62
	Dhusisi		1. Decedent's Name (First, Middle, I	Last)							2. Date of Dea	ath Day	Year	3. Time of De	eath
No.	Physici /Medic		Elsa M. Val								Januar		2004	9:06F	) M
14	Examin	er	4a. Facility Name (If not institution, g	tive street and number	er)				Location o	of Death			inty of Death		
			Suburban Hospit  5. Social Security Number 6		Age (in vrs	last birthday)	Beth If Under		If Under a	24 Hrs.	8. Date of Birt	h	tgome 1	ry plece (State or F	oreian
	Funeral Director		261-71-5195	1 M 2 XF	80			Days	Hours	Min.	(Month, Da June 2	y, Year)	Cou	ntry)	o, a.g.,
	ט		Usual Residence of Decedent								oune 2	, <u> </u>			
	nylan how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. fnside City I 1 ☐ Yes 2	
	Ba-f	cto	Maryland Montgo	mery	Pot	omac							/ N		AINO
	with the	Funeral Directo	10e. Street and Number				10f. Zip					10g. Citizen			
	eath v	eral	1490 Dunster Lan	12. Was Deceder	nt Ever in II	S 13		854	spanic Orio	gin? (Spe	cify Yes or No		d Stat		
	r Iter	Fun	1 Never Married 2 Married	Armed Force	s?					Puerto I	cify Yes or No Rican, etc.)	E	Black, White,	, etc.	
8	urs a	þ	3 Widowed 4 Divorced	II Yes, Give Year or Dates	-		1 <b>X</b> Yes 2	!□ No	Specify:	Span	ish	Spe	wify: Wh:	ite	
2-0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumatic event, the Mary Sal Examitment in tall bu mailling at	Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Usual kind of worl DO NOT use	l Occupa k done d	tion uring most	t of workin	ng	16b. Kind o	f Business/In	ndustry	
2	ifthin ne.	npl m	Elementary/Secondary (0-12)	Colfege (1-40	or 5+)										
2	lled w lygiel her tl	Ö	12 17. Father's Name (First, Middle, La	net)		Home	maker		18 Mothe	r's Name	(First, Middle,		Home	· .	
anc	e d is b	Be										maiddi dan			
Ž	should nd Men marke umatic	ဥ	Jose V. Morague			19b. Mailir	ng Address	(Street a			ronga I Route Numbe	r, City or Tox	wn, State, Zij	o Code)	
2	ulth ar 27 is r trau		Alberto Val/Husb			1490	Duns	ter	Lane	, Pot	omac,	Marvla	nd 20	0854	
ē,	of Head		20a. Method of Disposition		1 0	Place of Dispo	sition (Nam	e of	- 1	D	ate ary 28		on - City or T	own, State	
Ë	Pages nent of ant: If it		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State city)	<sup>тө</sup>  Моп	itgomer matori	um, I	nc.	į	2004		Bethes	sda, M	aryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature al Service Lic	ens		22 D.o.	Name and	d Address	s of Facility	y Rob	ert A.	Pumphr	rey Fu	neral Ho	ome/
	207 2 2		Mide	Jeen,							West M 20850		ery Av		
	Physician		Part1. Enter the disease, or co shock, or heart faifure. List on Immediate Cause (Finaf disease or condition	nly one cause on each	line.	h. Do not ent		of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	en ath
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):								, , , , ,	
В	LXAIIIIIIGI	_	Sequentially list conditions, if any, leading to immediate	17.	as a consequ	INTESTI.	NAC BC	.00011	V 6					3415	
	ted nsit	nlne	Cause (Disease or injury	,		US 13 = U	2 1148	7.1u16	e R					YEARS	
	execunand and all-tra	Examiner	that initiated events resulting in death) Last		as a conseq		/ ///	0 10 0						10/130	
760,	ate be executed hysician and the burial-transit	call		d											- 4.7
89	nificat ng phy as th		IT FELLAL E.												-
. Box	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/ms?	23c. If yes, outcom 1 ☐Live birth			Ectopic pre	gnancy					Date of deliver	ery Day Yea	ar
	e dea the at hed fo	slcl	1 Yes 2 No	4□Pregnant 9□Unknown		eath 5	Other (spe	ecify)						52,	
0.0	res that the de signed by the a be detached f		Part II. Other significant conditions	s contributing to death	but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use c	ontribute to t	he cause of dear	th?
Division of Vital Records,	uires signe d be	d by	_	10 PENIA,							101	es 2 No	3 ☐ Prot	bably 4 Unk	nown
S	w requ	Completed		/							24a. Was	an 24	b. Were auto	opsy findings ava	ailable
He He	The lav	шс									autop perfo	sy med?	prior to co death?	mpletion of caus 2□ No	se of
ta		0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	2L N0	
5	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	itient 2	ER/Outpatier	nt 3 DO	A Othe			ne 5 Resid		Other (Specia	fy)	
0	Attending Physician: r death. ector: After this certifics by the funeral director, i		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of fnjury	f 28	c. Injury Work			8d. Describe h				
S	Ntendii death. ctor: A y the fu	catle	2 Accident investigat 3 Suicide 6 Could not	t he			М		es 2 🗆 N						
Ë	or Atl	Certification:	4 Homicide determine	286. Place of	Injury - At ho etc. (Specifi	ome, farm, str y)	eet, factory,	office		2	18f. Location (S City or Tow		mber or Rura	al Route Number	r,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying	Physicien: To the be	st of my kno	wledge, deatl	h occurred a	it the time	e, date and	d place, a	nd due to the	ause(s) and	manner as s	tated.	
	in 24 he Fu pletel	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner	or examina stated.	tion and/or in				m occurre					
	Vith.	Σ	29b. Signature and title of certifier	1 ruit A	dun	CMD		License				29d. Date sig			
7	6								9256		J	IANUA		0001	
			30. Name and address of person wh				Print) MERY	AU	BETH	tCS DA	1 M.D	20114	<i>'</i>		
-telle "	Sta Registr		31. Date fifed (Month, Day, Year)  JAN 28 2	.004 32. Pegis	strar's Signa	ture	Spa	eks	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 2004 23 Jan /Medical 4c. County of Death give street and number) 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, Examiner Washington 1acoma arte bitai MOMENT C If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (If yrs. lest birthday) **Funeral** 1 1 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 - Yes 2 No DC Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Avenue 20011 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ites any injury or other traumatic event, the Medical Enatural and 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Industra Janitar 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wills Smith Doris William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dovis S Washing ton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 1-29-2004 Olivet Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Service Washington De 20003 , SE · Potomac Ace Fart1. Enter the distase, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗆 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforri After this certificate 1 Yes Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient Medical Certification: To 1 ☐ Yes 2 No 3 DOA 27. Manner of D- ath 28a. Date o Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

**JAN 26** 

SSIE Registrar's Signature

4			1 - For State Registrar	State of Marylar	•		f Health and of Death	Re	g. No. 2004	04264
4	Physici /Medic	•	1. Decedent's Name (First, Middle, Last) Edward Willia	ms Sr.				2. Date of Death Month	Day Yeer	3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give s  of in C C C C C C C C C C C C C C C C C C	7. Age (In yrs.	last birthday) 56 Yrs.	Che If Under 1 Y	on, or Location of Dea Weel ear If Under 24 Hi ays Hours Mil	s. 8. Date of Birth	Year) Cour	′′ 11/
第二			Usual Residence of Decedent  10a. State 10b. County  MD Prince G	10c. Ci	ty, Town or Lo	cation		may 4,		hington  10d. Inside City Limits
	72 hours atter death with the Maryland netural', or teme 23a or 28a-f show ifral Examinet must be natified at	Funeral Director	10e. Street and Number 4405 73rd Ave.	2. Was Decedent Ever in U		10f. Zip Coo			g. Citizen of What Cour	
-0036	72 hours after of netural, or Italian		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	16a. Dece	1 Yes 2	No Specify:	1	Specify: B 1  6b. Kind of Business/In	lack
121215-0036	be filed within 72 hartal Hygiene. Ind other then "neture event, the Medical	Completed by	(Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	(Give	kind of work do	er	orking	Private	
Maryland	d 2 should be fi th and Mental H 7 is merked of traumatic ever	To Be	17. Father's Name (First, Middle, Last)  Thomas Wi  19a. Informant's Name/Relationship (Typ.	lliams pe, Print)	19b. Mailir	ng Address (Sti	Blan	Rural Route Number.	elt City or Town. State. Zin	o Code)
	es 1 and of Health I item 27 r other t		Edward Williams  20a. Method of Disposition  1	20b. F	Place of Dispo	5 73rd sition (Name o natory or other	f place)	Date 2	e, MD 20	own, State
Baltimore,	Pedmit, Pages Department of Importent: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Har	22	Cemete Name and Ac 722 No	diess of Facility T	ay⊥or's	andover, Funeral H NW Wash.	MD lome DC 20001
198	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	th. Do not ent					Approximate Interval Between Onset and Death
8760,	death certificate be executed to attending physician and ad for use as the burial-transit.	licai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
.O. Box 6	that the death certific led by the attending p detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	aldéath 3□	Ectopic pregna			23d. Date of delive Month	ery Day Year
rds, P	The law requires that the side has been signed by the bage 2 should be detache	Ď	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause	given in Part I.		acco use contribute to the	/
Vital Records,		Completed						24a. Was an autopsy perform	ed? prior to con	psy findings available mpletion of cause of 2 \( \text{}\) No
Vit.	Physician: this certificantal director,	Be	25. Was case referred to medical examiner?	ospital:			Other	eath (Check only one		
of	Phys rat di	. T	1 Yes 2 No	1 ☐ Inpatient 2☐ 28a. Date of Injury	ER/Outpatien 28b. Time of		4 🗀 Nursing	Home 5 Resider 28d. Describe how	ce 6 Other (Specify	(v)
Division	or Attending after death. Director: After in by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)  28e. Place of Injury - At hi	Injury ome, farm, str	М	njury at Work? 1 ∐ Yes 2 ∐ No ice	28f. Location (Stre	eet and Number or Rura	al Route Number,
Δį	pitel or ours afte serei Din filled in		29a Certifier 1 Certifying Phys	building, etc. (Specifician: To the best of my known or: On the basis of examina	owledge, death	occurred at th	e time, date and place	City or Town,	Ise(s) and manner as st	lated.
		edical	one)	and manner stated.	ation and/or in	restigation, in i	ny opinion, death oct	curred at the time, dat	e and place, and due to	) the cause(s)
	To the vithin To the comple	Σ	29b. Signature and title of certifier	flitte 2	>0		toos number		d. Date signed (Month,	Day, Year)
-	U		30. Name and address of person who con	Pu, 3001/	tospit.	Print)	ve Ch	everly	MAN 14	24
	Sta Registr		JAN 2 7 2004	82. Registrar's Signa	ature			//		

MAN			1 - For State Registrar	State o		ertificate of Deat	h	giene Reg. No. 2004	04265
	Physici /Medi		1. Decedent's Name (First, Middle Lidia Z. Wenz	die, Last)			2. Date of De Month Januar	Day Year	3. Time of Death 0120 A
	Examir	ner	4a. Facility Name (If not institute Southbound 183 Sc			4b. City, Town, or Location Cockeysvil	le	4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 061–58–6713	6. Sex 1 ☐ M 2 <b>[</b> 2] F	7. Age (In yrs. last birthda) 44 Yrs.	/ If Under 1 Year If Und Months Days Hour			place (State or Foreign ntry) W York
	Maryland -f ehow fied at	tor	Usual Residence of Decedent  10a. State 10b. Count  MD Anne	Arundel	10c. City, Town or I	ocation Csville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the Ma 23a or 28a-f	al Direc	10e. Street and Number 761 Stacy Oak	Way		10f. Zip Code 21108		10g. Citizen of What Cou USA	ntry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be natified at	by Funeral Director	11. Marital Status  1 Never Married 2 Name 2	rried 1 Tes	rces? 2.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi  1 ☐ Yes 2 ☑ No Spec	can, Puerto Rican, etc.)	o- 14 Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	within 72 ho nne. Ihan "natur is Wedical I	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed) College (1	-4or 5+) (Giv	edent's Usual Occupation e kind of work done during m DO NOT use retired) Child Psychiat		16b. Kind of Business/In	•
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mone.	To Be Co	17. Father's Name (First, Middle Michael Palcar			18. Ma	ther's Name (First, Middle ephania Huge	, Maiden Sumame)	
, Maryland	and 2 shou laith and M 27 is mar ar traumat		19a. Informant's Name/Relation Fred Wenz/Fath			ling Address (Street and Num Circle Drive		er, City or Town, State, Zij le, NJ 08876	code)
Baltimore,	Pages 1 ament of He ment of He lant: If Itam jury or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 1 □ Donation 5 □ Other (	Specify)	20b. Place of Disp cemetery, cre Meadowri	osition (Name of ematory or other place) dge Mem. Park	January 24 2004	Elkridge,	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	o Lo	100000	2. Name and Address of Fa Pranco & Sor 195 Gov. Ritch	is. P.A. Sev	verna Park Fi verna Park, 1	uneral Home
	Physician /Medical Examiner		23a Fart1. Ever the disease, shoot, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a	Type Injury or as a consequence of:	nter the mode of dying, such	as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence of):				
O. Box	death certifi e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live b	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
ords, P.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condit	ions contributing to de	eath but not resulting in the	underlying cause given in Pa	rt I. 23e. Did t	obacco use contribute to the Yes 2 No 3 Prot	he cause of death?
Il Records,	The ate h page	Completed					24a. Was autor perio 1XYes	psy prior to co ormed? death?	psy findings available mpletion of cause of
of Vital	ysician is certifi director	: To Be	25. Was case referred to medic examiner? 1√2 Yes 2 ☐ No 27. Manner of Death	Hospital:	npatient 2 ER/Outpatie	ont 3 DOA Other: 4	20d Describe I	dence 6 QOther (Specif	) At scene
ision	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Certification:	1 Natural 5 Pend 2 Accident invest 3 Suicide 6 Could	ing (Mont 1) 2 (I not be mined 28e. Place	of Injury - At home, farm, s	Work? 1 ☐ Yes 2	840 Collider	MOTOR VENICIONE WHY AND VENICIONE Street and Number or Rura	
	To the Hospital or A within 24 hours after To the Funaral Directompletely filled in by	edical	29a. Certifier 1 Certifyi (Check only one)	ing Physician: To the I Examiner: On the ba and mann	isis of examination and/or i	th occurred at the time, date nvestigation, in my opinion, d	and place, and due to the eath occurred at the time,	cause(s) and manner as's date and place, and due to	tated. the cause(s)
	To T To T	×	29b. Signature and title of certifi	. M.D		29c. License numbe	ir .	29d. Date signed (Month,  January 20,	
			30. Name and address of person	. m.D	11:	Print) 1 Penn Street	, Baltimore,		
	Sta Registr	ar	31. Date filed (Month, Day, Year JAN	2 8 2004 32. R	egištrar's Signature	front			

DHMH 17 Rev 1/2001

AN	Ī		1 - For Stete Registrar	Sta	te of M	arylan	d / Depa		nt of H te of			lental H		ene 20	04	0426	6
	Physici /Medio		1. Decedent's Name (First, Mid James F. Wenz	s, Sr.								2. Date of I Month Janua		20, 20	Yeer 04	3. Time of Death	
}	Examin	er	4e. Fecility Name (If not institute Southbound 183 Sc	uth of Pa	donia I	Road		Co	r, Town, o ckeys er 1 Year	svill		0.0	N. A.	4c. County o	imor		_
	Funeral Director		5. Social Security Number 156-64-8108 Usuel Residence of Decedent	6. Sex 1 ☑ M 2	1 7	40	/ast birthday) Yrs	Months		Hours	Min.	8. Date of E (Month, I NOV.	26,	1963	Coun	lece (Stete or Foreigr try) York	_
	Maryland	tor	MD 10b. Coun	y Arundel		1	y.Town or Lo Iillers		е						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ath with the 23e or 28	Funeral Director	10e. Street and Number 761 Stacy Oal-	: Way				10f. Z	ip Code 21	108			10g	Citizen of WI	hat Coun	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itama 23e or 28e-f ehow any injury or other traumatic event, If a Medical Examinar mast be inclined alonge.	þ	11. Maritat Status 1 □ Never Ma <i>rr</i> ied 2 <del>Q</del> Ma 3 □ Widowed 4 □ Divorce	urried 1 [	s Decedent ned Forces? ]Yes 2 ☑ es, Give ar or Dates:	,		If Yes, sp	edent of Hecify Cuba 2½ No	lispanic O an, Mexica Specify	an, Puerto	ecify Yes or I Rican, etc.)	No-	14. Race Black Specify:	, White,		
Maryland 21215-0036	l within 72 ho iene. r than *natu	Completed	15. Decedi (Specify only high Elementary/Secondary (0-12		eleted) llege (1-4or	5+)	life.	kind of w DO NOT	ork done use retired	during mo 1)	st of worki		16	b. Kind of Bus		dustry	
yland 2	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle Fred Wenz	a, Last)						Ņ	[adeli	ine De	Bar				
	1 and 2 sho Health and Am 27 is m		Fred Wenz/Fat  20a. Method of Disposition		nt)	205 0		ircl	e Dri		Some		ອ, ີ	NJ 088	76		
altimore,	it. Pages idment of h ident: if Ita njury or of		1 🖾 Burial 2 🗀 Cremation 1 🖾 Donation 5 🗀 Other 21. Sign ure 1 Funeral Serve	(Specify)	I from State	0	adowric	natory or dge N	other plac	Park	Janu 20	ary 24	20	Elkrid	-		
Ba	permit. Departinoport. Import. any inj		23a. Part V. Enter the disease, shack, or heart failure. Li	100	JJQ that cause	nCe	B 4	arra 95 G	nco 8	& Son Ritch	s, P. ie Hv	A. Se	eve eve	rna Pai rna Pai	ck Fi	uneral Hom MD 21146 Approximate	e
¥.	Physician /Medical Examiner	ler	speck, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	Oue to (or as	a consequ	Z N I	urie								Interval Between Onset and Death	
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Oue to (or as	a consequ	uence of):										
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 C 4 C	es, outcome ]Live birth ]Pregnant a ]Unknown	2 Fetal	death 3	]Ectopic   ] Other (s	pregnancy pecify)					23d. Date Mont		ry Day Year	
rds, P	w requires that been signed t should be det	by	Part II. Other significant condi	tions contributir	ng to death b	out not resu	ulting in the ur	nderlying	cause giv	en in Part	1.		tobac Yes	5.7		e cause of death? ably 4 Unknown	
al Reco		Completed										1 X Yes	opsy formed 2 [	d? de		osy findings available npletion of cause of 2 No	
Division of Vital Records,	Attending Physic death.  • death.  • ctor: After this by the funeral did	Certification: To Be	3 ☐ Suicide 6 ☐ Coul	Hospita 28a ling tigation	Date of Inju	y Yeer)	me, farm, str	Ам	28c. Injun Work	er: 4□N yat	lursing Hor	assen assen	sidence how CY, Wi (Street	injury occurred WWO)C	rve	At scene nicle which nous vehicl Route Number, ionia Rd	1
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edicai C	29a. Certifier 1 Certify (Check only one)	ing Physician: Il Examinar: Or an	To the best the basis of d manner st	f examinat	wledge, death tion and/or inv	occurred estigation	at the tin	ne, date a pinion, de	nd place, a ath occurre	and due to th	e caus	e(s) and man	ner as st	ated. the cause(s)	
,	To the within 2 To the complete	Me	29b. Signature and title of certification (Control of Control of C	mil	2				O.C.N					Date signed of anuary			
	CA		30. Name and address of personal Control Con	I. M.D		death (Item	111		Str	eet,	Balt	imore,	Ma	ryland	212	01	_
	Sta Registr		JAN 2		Alla	1000 A	B A		8								

Registrar

			For Stete Registrar	State of Ma	ryland /		rtment of H tificate of L			iene <sub>eg. No.</sub> 2001	+ 04267
	Physici		1. Decedent's Name (First, Middle, Las GLADYS EL J	ZABETH	WAII	NWRIC	HT		2. Date of Dea Month JANUARY	Day 2004	3. Time of Death 5:08 p <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, give 31570 Melson Rd.	street and number)			4b. City, Town, or Delman		1	4c. County of De	
	Funeral Director		5. Social Security Number 6. S. 214–10–8507 1		o (In yrs. last 91	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 2	(2,1912) 9. B	irthplace (State or Foreign Country) Maryland
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	tha Mar 28a-fal	Director	Maryland Wicomic	:0	Deli	mar	10f. Zip Code			Og. Citizen of What (	1 ⊠Yes 2 □ No
	h with 23a or	al Dir	604 E. Pine St.				21875			USA	,,
9	permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f ahow any injury or other traumatic avent, Its Medical Evaluation could be notified at Albert.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give			Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		nerican Indian, nite, etc. White
2-00	72 hours natural', lical Ex	eted by	3 ⊠Widowed 4 □ Divorced  15. Decedent's Ec (Specify only highest gra	Year or Dates:	10	6a. Deced	ent's Usual Occupa	ition	kina	16b. Kind of Busines	
21215-0036	d within giene er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	00 NOT use retired, seeper/mar	)	9	construct	ion/motel
Maryland	d be fila ental Hyg rad othe c avent,	To Be C	17. Father's Name (First, Middle, Last) Anthony Lee Livi	naston			•	18. Mother's Nan	ne <i>(First, Middle, i</i> tte B <b>ro</b> v	Meiden Surname)	
lary	2 shoul and M is mari surnati	F	19a. Informant's Name/Relationship (	Гуре, Print)	1			and Number or Ru	ral Route Number	, City or Town, State	, Zip Code)
	1 and 1 Health em 27 ther tr		Shirley Pavone/da  20a. Method of Disposition	ughter	20b. Place	of Dispos	O Melson		-	21875 20c. Location - City of	or Town. State
Baltimore,	Pages ment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	<i>(</i> )	ceme	U.M.C	natory or other place hurch Cemet	ery 1/2	3/04	Salisbury	, MD
Bai	permit Depart Impor any in		21. Signature Funeral Service Licen	man)	CFSF	1   5	OI Snow I	HILL Rd.	, Salisbu	ırv, MD 21	Association .804
	Physician		23a. Part1. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final	olidations that caused one cause on each lin	the death. C			g, such as cardiad			Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence			(	Urles	1 Mseas	
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequence	ce of):	<u> </u>				
o,	icate be exacutad physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence	ce of):					
38760,		dlcal	•	d							
P.O. Box (	Physician: The law requires that the death certificare that secrificate has been signed by the attending plant director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	ath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
	uires that the de signed by the a d be detachad t	by	Part II. Other significant conditions of	ontributing to death bu	at not resulting	g in the ur	derlying cause give	en in Part I.			to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	The law requirence to the has been single 2 should I	Completed							24a. Was a autops perform	ry prior to med death?	
Vita	ician: sertifica ector, I	Be	25. Was case referred to medical examiner?	Hospital:			Othe		th (Check only on	θ)	Durinters
ion of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely illed in by the funeral director, page	atlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28t	Outpatien b. Time of Injury	28c. Injury Work	4   Nursing H		ence 6 <b>(36</b> 0ther (Sp ow injury occurred	ecity)
Divis	after des Director	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At home, (Specify)	, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C		ysician: To the best of niner: On the basis of and manner sta	examination						
	To the within To the comp	M	29b. Signature and title of certifier	mp			29c. License	19127	2	9d. Date signed (Mor	nth, Day, Year)
R			30. Name and address of person who Alson DAMS imp		eath (Item 23	a) (Type, I		alisban	n mo	71804	
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 2 2		r's Signature	1 114	Spark	í (			

			For State Registrar	State of M	aryland / De	epartme Certifica			nd Mei		ne . No.	2004	04	268
- Pri	Physici /Medio	al	Decedent's Name (First, Middle, La     MOZELLA M. WOLFE     4a. Fecility Name (If not institution, give			45 6	town or	r Location of [		Date of Death Month 01	Day 20	Year 2004 ounty of Death	3. Time of 8:42	
	Examir	er	ANCHORAGE NURSING 5. Social Security Number 6.5	HOME	e (In yrs. last birthe	SAL	ISBUR	Y If Under 24	Hrs. 8.	Date of Birth (Month, Day, Y	WICC	9. Birthp		r Foreign
	Director works J	or	Usual Residence of Decedent	CO	10c. City, Town of SALIS	or Location				5-30-19	1 /	OKLA	HUMA  Od. Inside Cit	
	h with the h 3a or 28a-	ai Direct	10e. Street and Number 209 W. COLLEGE AV		57225	10f. 2	Zip Code			10g	. Citize	n of What Cour	ntry?	
036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show ta Mudical Exatia ear must be codified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:		If Yes, sp	cedent of H pecify Cuba 2111 No	ispanic Origin In, Mexican, F Specify:	n? (Specifi Puerto Ric	y Yes or No- an, etc.)		Race - Americ Black, White, pecify: WH		
21215-0036	d within 72 ho giene. or than "natur It e Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12			ife. DO NOT	work done o	during most o	f working	16		of Business/In		
Maryland	nould be file I Mental Hy narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last JAMES DAVID LANGI	EY	401		(3)	ADA CA	ATHER	INE HAM	ILT	ON		
e, Mai	1 and 2 st Health and em 27 Is n ther traun	5.0	19a. Informant's Name/Relationship ( ELICHIA A. VENSO-  20a. Method of Disposition	** .		W. CC	LLEGI			LISBURY	, M		21801	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Mudical Exand set must be invitted at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Emeral Service Lice	y) _	CREMATO	RY OF 22. Name	DELMA and Addres	ARVA 01	1-21- BOUN	2004 D	ELM RAL	AR, DEL HOME,	AWARE	00/
7 7	Physician /Medical Examiner		23a Far1. Enter the disease of comshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	d the death. Do no ne.	t enter the m		g, such as ca		SALISB espiratory arrest		, FIARTE	Approximate Interval Betwonset and D	veen leath
3760,	ate be executed hysician and the burial-transit	ilcal Examiner	Sequentially list conditions, a year growth course. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of								7,00	<b>-</b>
.O. Box 68	res that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal death	3 Ectopic					230	I. Date of delive Month		ear
<u>α</u>	The law requires that the ate has been signed by th page 2 should be detache		Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying	g cause give	en in Part I.		23e. Did tobac		contribute to the		
Vital Records,		Completed							-	24a. Was an autopsy performe 1 ☐ Yes 2 ☑	d2-	24b. Were auto prior to con death? 1 \(\sum \text{Yes}\)	mpletion of ca	vailable use of
of Vita	ding Physician: h. After this certification funeral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie		atient 3 🗆	DOA Othe	-		Check only one) 5 ☐ Residenc	e 6[	Other (Specif	y)	
Division o	tending leath. tor: Alter the fune	Certification:	27. Manner of Death  1 Matural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	e 29a Place of Ini	y Year) 28b. Tin Inju	ury M		/ at <br Yes 2 □ No		Location (Stree			d Route Numb	per.
<u>\\ \</u>	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide determined	building, et	c. (Specify)  of my knowledge, (	death occurre	ed at the tim	ne, date and p	place, and	City or Town, S	State)	d manner as si	tated.	
	To the Hi within 24 To the Fu completel	Medical	29b. Signature and title of certifier	niner: On the basis o and manner st	t examination and/ ated.		on, in my op 29c. License		occurred			igned (Month,		
		1	30. Name and address of person who	completed cause of a	eath (Item 22a) (T-	(De Priot)	009	51359			20	2 ist 20	04	
1	DC			S. DIVISIO  32. Registr			ury	^	10 21	1804				
	Sta Registi		31. Date filed (Month, Day, Year)	004 Sen	ai s Signature	9 de	souks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 2004<sup>Year</sup> Physician 29, Jan. Francis Joseph Worcester 10:30AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles County Nursing & Rehab LaPlata Charles If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Aug 24 If Under 1 Year Birthplace (State or Foreign Country)
 NY 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys **№** M 2□ F 059-24-7375 82 Yrs. Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 € No **Funeral Director** MD Charles LaPlata 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 8960 Darley 20646 USA 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No If Yes, Give Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) James B. Worcester Mary L. Bloom Worcester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Worcester/Son 11965 Amy Dr. LaPlata,MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Sacred Heart Ch. Cem. 2/2/04 LaPlata, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup>AREHARTS ECHOLS FUNERAL HOME, PA MOO945 P.O. Box 567 LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine Attanding Physician: The law requires that the death certificate be executed as the buriel-trensit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last ed by the attending physician and deteched for use as the buriel-trer Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of). Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ours efter death.

•ral Diractor: After this certificete hes been signs filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1\_Yas 2⊠No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P001009

State Registrar 31. Dete filed (Month, Day, Year) FEB 0 2 2004

Burke, M.D.

Henry L.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

115 LaGrange Ave. LaPlata, MD 20646
32 Pogistra's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last)
Sylvia Mildred 2. Date of Death WINE Jamuary 20, 2004 Svlvia **Physician** 9:10p M /Medical 4c. County of Death Montgomery 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Friendship Heights 4550 N.Park Ave. #713 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. March 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 → F 1921 Virginia Director 225-16-8058 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r than "neturel", or Items 23s or 28s-f show the Medical Examiner must be notified at Friendship Heights Montgomery 1 Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4550 N. Park Ave. U.S.A. 20815 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "neturel; or Item eny nigury or other traumatic event, the Mudical Expris 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Jewish Council for Aging Elementary/Secondary (0-12) College (1-4or 5+) Volunteer 12 17. Father's Name (First, Middle, Last)
Louis 18. Mother's Name (First, Middle, Maiden Sumame) Be Weiss B1um Minnie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8601 Carlynn Drive, Bethesda, MD 20817 / son Mark Wine 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Forest Lawn Cemetery January29,2004 Norfolk, VA 4 ☐ Donation 5 ☐ 9ther (Specify) 21. Signature of Fungral Service Licenses 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St. N.W., Washington, D.C. 20012 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached Division of Vital Records, P.O. the 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 des 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s has certificate 1□ Yes 2□ No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 3 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann Death 28d. Describe how injury occurred 28b. Time of After 1 Natural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 MCCONNELL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), کلر 11 1500A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1	For State Registrar	State of	Maryland		artment o			Mental Hy	giene Reg. No.	2004	04271
			Decedent's Name (First, Middle,	Last)	<del></del>					2. Date of De	aath Day	Yeer	3. Time of Death
	Physicia /Medic		ESTHER S	WHITE						JANUAR	Y 24,	2004	1:37 A M
9	Examine		a. Facility Name (If not institution,		ber)		4b. City, To			h		ounty of Deeth	
			SUBURBAN HOSPIT		A 11 1		BET	HESDA	Jnder 24 Hrs	8. Date of Bi	reh	ONTGOME	ERY uplace (State or Foreign
	uneral	1		5. Sex 7. 1 ☐ M 2 ☐ F	. Age (In yrs. I	ast birthday): Yrs.			ours Min.		ay, Year)	CHI	intry)
D	irector	}-	539-32-3938 Usuel Residence of Decedent	X	81		L			DEC. 0,	1762	OHII	441
land	N 18		10a. State 10b. County		10c. City	. Town or Lo	ocation						10d. Inside City Limits
Мал	28a-f ehow notified at	ţ	MARYLAND MONTO	COMERY	RO	CKVILL	E						1 Xes 2 No
t te	or 28s	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What Cou	untry?
death with the Maryland	23a c	a	10201 GROSVENOR	R LANE, #1	103			852				TED STA	
r dea	rat', or iteme 23a or 28a-f ehor Examiner must be notified at	Funeral	11. Marital Status	12. Was Deced Armed Ford	es?		Was Deceden If Yes, specify	nt of Hispar Cuban, M	nic Origin? (S exican, Puer	Specify Yes or N to Rican, etc.)	0- 14	Race - Amer Black, White	
36 alte	or it		1 Never Married 2 Marrie	ed 1 Towes 2 If Yes, Give	<sup>1</sup> □Nº 195	2-	1 ☐ Yes 2 ☐	XNo Sp	pecify:		s	Pecify: WHI	rc
21215-0036 within 72 hours alter	natural',	pd by	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	les: 1972		dent's Usual (	Occupation				of Business/I	
15 n 72	natur	Completed	(Specify only highest	grade completed)		(Give	kind of work	done during	g most of wo	orking			·
2 E	than the	E	Elementary/Secondary (0-12)	College (1-4	40r 5+)	ADMIN	ISTRAT	IVE A	SSIST	ANT	FED	ERAL GO	OVERNMENT
D 5	ent,	Be C	17. Father's Name (First, Middle, L	ast)						me (First, Middle	, Maiden S	umame)	
<b>a</b> be	fenta rked lic ev	ToB	SHMUEL SHOT	RNICK				F	RIVA		VAR	GAR	
Maryland	and N		19a. Informant's Name/Relationsh	ip (Type, Print)						ural Route Numi			(ip Code)
Z purd 5	alth a		SIMONE ROCKSTRO	OH, NIECE			-		DAD, W	OODBINE,		21797	
ore.	the H		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Ramoval from S		lace of Dispo emetery, crea	osition (Name matory or othe	of er place)		Date		ation - City or 1	
Page	ourtment of sortant: If it is vinjury or contact of sortant or contact of sortant or contact of sortant or contact of sortant or contact or con		' 4 □ Donation   5 □ Other (Sp	ecity)	MT.	LEBAN	ION CEM	ETERY	1/2	7/2004	ADEL	PHI, M	ARYI.AND
Baltimore,	Department of Health and Mental Hygiene, Important: if Item 27 is marked other than any injury or other traumatic event, Ita Maones.	I	21. Signature of Funeral Service V	hcensee	4	DA		Y-G01	<b>LDBERG</b>	MEMORIA E, ROCKY			INC. 0852
	4.		23a. Pert 1 Enter the dise sa or o	complications that ca	used the death	n. Do not en	ter the mode	of dying, su	ich as cardia	c or respiratory	arrest,		Approximate Interval Between
Die	velejon		shock, or heart fail re. list of temmediate Cause (Fina	only one cause on ea		2129							Onset and Death
	ysician Medical		disease or condition resulting in death)	a. Due to (c	or as a consequ								
Ex	aminer			(	721516	rice	JV-AR	F	BRI	OTTAN	6		
110	tyri 3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq								
penno	hysician and the burial-transit	Examiner	that initiated events	С									
10°	an an		resulting in death) Last	Due to (d	or as a conseq	uence of):							
675 8760	ysici he bu	lical		d									
6 ≅	attending ph	Physician/Medical	IF FEMALE:										10
OH Sox	ttend or use	lan/	23b. Was decedent pregnant in the past 12 months?		rth 2 Fete	death 3	□Ectopic preg				23	3d. Date of deli Month	ivery Day Year
2.4	by the a tached t	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□Unkno	ant at time of d wn	eath 5	Other (spec	:пу)					
P.O.	d by Jetac		Part II. Other significant conditio	ens contributing to de	ath but not res	ulting in the c	underlying cau	se given in	Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ds,	signed I	1 by								1 🗆	]Yes 2.⊠	No 3□Pr	obably 4 \( Unknown
A 2 8	been si	ete						,		24a. Wa	s an	24b. Were au	itopsy findings available
Record ne law requir	has l ge 2 s	ompleted								aut	opsy formed?	prior to death?	completion of cause of
上 曾 明	is certificate h director, page	O							. Diam4.0	1 Yes		1 Ll Yes	21 No
Vital Vicion:	certif	Be	25. Was case referred to medical examiner?	Hospital:	npatient 2	EB/Outpatio	ent 3 DOA	Other		eath (Check only Home 5 Re		□Other (Sne	cify)
W 2 E	rthis raldii	1: To	1 ☐ Yes 2 ② No  27. Manner of Death		of Injury h, Day Yeer)	28b. Time o		c. Injury at Work?	+ C Iddishig	28d. Describe			ony)
On	h. Atter funer	tion	1 ♣ Natural 5 Pending 2 Accident investig	9	h, Day Yeer)	Injury	М		2 🗆 No				
Vision	death.	fica	3 ☐ Suicide 6 ☐ Could r	ined 200. Flace	of Injury - At h	ome, farm, si	treet, factory.	office		28f. Location	(Street and	Number or Ru	ural Route Number,
于台	Dire d in b	Certification:	4 Homicide	buildir	ng, etc. ( <i>Specii</i>	(y)				City of 1	Own, State)		
HOSPITAL OF	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  Certifyin  (Check only one)	g Physician: To the Examiner: On the ba and mann	asis of examina	owledge, dea ation and/or i	th occurred at	t the time, on my opinion	date and plac on, death oc	ce, and due to th curred at the time	e cause(s) a e, date and	and manner as place, and due	s stated. to the cause(s)
To the	vithin i	Mec	29b. Signature and title of certifier		Λ.		29c.	License nu	ımber		29d. Date	signed (Mont	h, Dey, Year)
	100		<b>)</b>	) \			6	ters!	51280		1-	24-2	COL
13	>		30. Name and address of person	who completed caus	e of death (Iter	n 23a) (Type			J 1 C(				
			A. DAGDAR, M.I	10010 1				ACE,	GERMAI	NTOWN, M	D 20	874	
	St	ate	31. Date filed (Month, Day, Year)	32. Ps	agistrar's Sign	ature 🤌	- 1	uls					
	Regist	rar	JAN 28	2004	The same	1	apo	cas					

			1 - For State Registrer	State of Maryla	nd / Depa		leaith and N	nental Hy	giene	4 04272
	Physici	an	Decedent's Name (First, Middle, Las	William Euge	ene WEI	NER	-	2. Date of De Month	ath Day Ye	. 1
	/Medio Examir		4a. Facility Name (If not institution, give				r Location of Death	Januar	y 17, 2004 4c. County of E	+ 2:00 P
	LXGIIII	161	9816 Hellingly E				ersburg		Montgo	
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		579-40-6421 Usual Residence of Decedent 10a. State 10b. County	71	Yrs.			Feb. 2	3, 1933 Wa	ashington, DC
	he Maryis 88-f sho	ector	Maryland Montgome			ithersbu	rg			1 ☐ Yes 2 🔯 No
	ath with t	rai Dir	10e. Street and Number 9816 Hellingly I			10f. Zip Code	20886		10g. Citizen of Wha United	•
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show mainty or other traumatic event, the Medical Examinar must be notified at ORCE.	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2√☐ No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	14. Race - A Btack, V Specify:	American Indian, Vhite, etc. white
1215-0	vithin 72 h ne. han "natu n Medical	mpletec	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DD NDT use retired SMan	ation during most of work d)	ing	16b. Kind of Busine	ess/Industry
Maryland 21215-0036	uld be filed v Jental Hygie rkad othar t tic evant, th	To Be Co	17. Father's Name (First, Middle, Last)	2 Israel We				e <i>(First, Middl</i> e, la Stein	Maiden Sumame)	
Mary	nd 2 sho lith and N 27 Is ma r trauma	•	19a. Informant's Name/Relationship (7 Shane Spradlin, Sc				and Number or Rur ase Court		or, City or Town, Star MI 48098	
Baltimore,	ages 1 a ant of Hea it: If Itam y or otha		20a. Method of Disposition  1 St Burial 2 Cremation 3 .  4 Donation 5 Other (Specify	20b. Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c. Location - City	
Baltir	permit. F Departme Importan any injur		21. Signature of Funeral Service Electric	500	22 T	on Cemete Name and Addre orchinsky	ss of Facility	Funeral	Adelphi, Home, Inc	
,092	Physician and Asician xaminer	23a. Part1. Enter the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ventricular  Due to (or as a conse  Coronary Ar  Due to (or as a conse  Due to (or as a conse	r Fibri quence of): ctery D quence of):	llation	g, such as cárdiac	or respiratory as	rrest.	Approximate Intervat Between Onset and Death Minutes  Years	
P.O. Box 6876	The law requires that the death certificate be executed tite has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown	d	aldeath 3 death 5	Ectopic pregnancy			23d. Date of Month	Day Year
Records,	w requires to been signer should be d	ted by	Part II. Other significant conditions co	minouting to death but not re	suiting in the u	ngeriying cause giv	en in Part I.			e to the cause of death?  Probably 4 Dunknown
al Rec		Completed							osy prior rmed? death	e autopsy findings available to completion of cause of 1? res 2 \( \text{No} \)
Vital		) Be	25. Was case referred to medicat examiner?	Hospital:		t 20 DOA Oth	26. Ptace of Deat			
of	ding Talling After fune	tlon: To	1 Yes 2 No  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	4 🗀 Nursing no		dence 6 Other (5	Specify)
Division	ospital or Attending hours after death. Inaral Director: After y filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, str			28f. Location (S City or Tox		Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Direct completely filled in by	Medical	29a. Certifier 1 ∑ Certifying Phy (Check only one) 2 ☐ Medicel Exam	rsicien: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	S T with	Σ	29b. Signature and title of certifier	1000	do	29c. Licenso	082039		29d. Date signed (M 01/28/04	
	7		30. Name and address of person who co				in Dr d	225 01	new MD	20832
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature /	Spork		<i>223</i> , U1	iiey, Mi	20032

ian	Decedent's Name (First, Middle	11/30/04,BMW,	MbCo	Ce	rtificate of	Death	2. Date	Reg. N	lo.	3. Time of Dea
	LESTER	,,	1.7ETNE	BERGER			JANU	n Da	ay Year	
ical iner	4a. Facility Name (If not institution	n, give street and nur		EKGEK	4b. City, Town, o	or Location o	,		. 2004 c. County of Dec	11:15 A
10.	SUBURBAN HOSPIT	AT.			BETHESDA			MC	ONTGOMER	ΣV
	5. Social Security Number	6. Sex	7. Age fin yrs. la	ast birthday)	If Under 1 Year Months Days				9 Bi	rthplace (State or For Sountry)
	157-14-8714 Usual Residence of Decedent	1 <b>∑</b> M 2□F	-01	Yrs.		riodis		/1923		JERSEY
_	10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Lir
Directo	MARYLAND MONTGO	MERY	РОТО	MAC						1 □ Yes 2X
	10e. Street and Number				10f. Zip Code				itizen of What C	Country?
Funerai	11920 FROST VAL		dent Ever in U.S	13 1	20854	dispanio Osia	nin? (Specify Voc.	U.S.	A. 14. Race - Am	orican Indian
Fun	1 Never Married 2 Marr	Armed For	ces?	13.1	Was Decedent of H If Yes, specify Cubi	an, Mexican	Puerto Rican, etc	.)	Black, Wh	
bχ	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	9		1 ☐ Yes 2 🖾 No	Specify:			Specify: WH	ITE
Completed	15. Deceden			16a Dece	dent's Usual Occup	pation		16b. I	Kind of Business	
ple	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of work done DO NOT use retired	during most d)	of working			
Con		5+		SCIEN	TIST			DIA	MOND LA	BS
Be (	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name (First, M	iddle, Maide	n Su <i>mame)</i>	
ဥ	SAMUEL	W	EINBERG	ER		ANNA			GREENE	BERG
E 8	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	ng Address (Street	and Number	r or Aural Aoute N	u <i>mber, City</i>	or Town, State,	Zip Code)
	ANITA WEINBERGE	R/ WIFE		11920	FROST VA	LLEY				
	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation	3 □Removal from S		ace of Dispo metery, cren	sition (Name of natory or other plac	ce)	Date	20c. L	ocation - City or	r Town, State
	* 4 □ Donation 5 □ Other (S		PARK	LAWN N	MEM. PARK	0	1/30/2004	ROC	KVILLE,	MARYLAND
	21. Signature of Funeral Service	Licensee		ED\	WARD SAGE	ss of Eacility	ERAL DIR	ECTION	I. INC.	
h 11	Umarda	Budew	(Q)	109	91 ROCKVI	LLE P	IKE, ROC	KVILLE	, MD 20	852
Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a conseque	ence of):	VASCULAR					
dical		d.								
ě.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		th 2 ☐ Fetalo int at time of dea	death 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	livery Day Year
nysicia	9 Unknown									
ed by Physician/M		ns contributing to dea	ath but not result	ting in the ur	nderlying cause giv	en in Part I.			**	o the cause of death? robably 4 DUnkno
eted by P	9 Unknown	ns contributing to dea	ath but not resul	ting in the ur	nderlying cause giv	en in Part I.	24a. \	Yes 2 Vasan	No 3 □ P	robably 4 Dunkno
eted by P	9 Unknown	ens contributing to dea	ath but not resul	ting in the ur	nderlying cause grv	en in Part I.	24a.	Vas an autopsy performed?	No 3 P	utopsy findings availa
e Completed by P	9 ☐ Unknown  Part II. Other significant condition	ons contributing to dea	ath but not resul	ting in the ur	nderlying cause giv		24a. Y	Ves 2  Was an autopsy performed?	No 3 P	utopsy findings availa
Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner?				lou	26. Place	24a. 1	Was an autopsy performed? es 2 No	24b. Were all prior to death?	robably 4 Unknoutopsy findings availa completion of cause 2 No
To Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death	Hospital: 1 딾 In	patient 2 ☐ E	R/Outpatien	a ∃ DOA Oth	26. Place o	24a. 1 1 Y of Death (Chack o	Was an autopsy performed? es 2 No	24b. Were a prior to death? 1   Yes	robably 4 Unknoutopsy findings availa completion of cause 2 No
To Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 🔀 Ing. 28a. Date of (Month)	patient 2 ☐ E	P/Outpatien	t 3□ DOA Oth 28c. Injun Worl	26. Place o	24a.  1	Was an autopsy performed? es 2½ No	24b. Were a prior to death? 1   Yes	robably 4 Unknoutopsy findings availa completion of cause 2 No
To Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death	Hospital: 1 🖾 In.  28a. Date of (Month) gation not be 28e. Place of	patient 2 ☐ E. Injury , Day Year)	R/Outpatien 28b. Time of Injury	t 3□ DOA Oth 28c. Injun Worl	26. Place o er: 4 □ Nurs y at k?	24a.  1	Was an sutopsy serformed? es 2\(\text{N}\) No nly one) Residence ibe how inju	24b. Were a prior to death? 1   Yes	robably 4 Unknoutopsy findings availa completion of cause 2 No
o Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case reterred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin investig 3 Suicide 6 Could relemment of Death 4 Homicide 6 Could relemment	Hospital: 1 🖾 In.  28a. Date of (Month) gation not be 28e. Place of	patient 2 E Injury , Day Year)  of Injury - At hom g, etc. (Specify)	R/Outpatien 28b. Time of Injury ne, farm, stre	28c. Injun Worl M 1 =	26. Place of the series of the	24a. 1   Y of Death (Chack of Sing Home 5   1   28d. Described City of	Was an autopsy benformed? es 2 Nonly one) Residence ibe how injuice the causels the causels.	24b. Were an prior to death?  1   Yes  6   Other (Spe	robably 4 Unknor utopsy findings availa completion of cause 2 No scify)
Certification: To Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig 3 Suicide 6 Could referred to medical examiner?	Hospital: 1 🔀 Inggration gation to be building g Physician: To the be	patient 2 E Injury , Day Year)  of Injury - At hom g, etc. (Specify)	R/Outpatien 28b. Time of Injury ne, farm, stre	28c. Injun Worl M 1 =	26. Place of er: 4 □ Nursey at k? Yes 2 □ Nursey at expension, date and pinion, death	24a. 1   Y of Death (Chack of Sing Home 5   1   28d. Described City of	Was an autopsy benformed? Passidence ibe how injuing the form of	24b. Were an prior to death?  1   Yes  6   Other (Spe	robably 4 Unknorutopsy findings availa completion of cause 2 No scify)
edical Certification; To Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig 3 Suicide 6 Could must determine the condition one 1 Note of the condition	Hospital: 1 🔀 Inggration gation to be building g Physician: To the be	patient 2 E Injury , Day Year)  of Injury - At hom g, etc. (Specify)	R/Outpatien 28b. Time of Injury ne, farm, stre	28c. Injun Work M 1 = 2eet, factory, office coccurred at the time restigation, in my office	26. Place of er: 4 Nurse vat k? Yes 2 Nurse vat vat vat vat vat vat vat vat vat vat	24a. 1   Y of Death (Chack of Sing Home 5   1   28d. Described City of	Mas an autopsy benformed? Per 2 No. No. No. No. No. No. No. No. No. No.	24b. Were a prior to death? 1 Yes 6 Other (Speing occurred) and Number or Rie) and prior to death? 1 of the de	utopsy findings availa completion of cause a 2 No No Northy)  ural Route Number, s stated. s to the cause(s)
edical Certification: To Be Completed by P	9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig 3 Suicide 6 Could must determine the condition one 1 Note of the condition	Hospital: 1 28a. Date of (Month) pation on the cond be cond grant on the building physician: To the base and manner.	patient 2 E Injury, Day Year) of Injury - At hom of, etc. (Specify) pest of my knowl als of examination or stated.	R/Outpatien 28b. Time of Injury ne, farm, stre ledge, death on and/or inv	28c. Injun Work M 1 = 20cet, factory, office coccurred at the time restigation, in my office 29c. License MD 405	26. Place of er: 4 Nurse vat k? Yes 2 Nurse vat vat vat vat vat vat vat vat vat vat	24a. 1   Y of Death (Chack of Sing Home 5   1   28d. Described City of	Mas an autopsy benformed? Per 2 No. No. No. No. No. No. No. No. No. No.	24b. Were an prior to death?  1   Yes  6   Other (Speing occurred)  and Number or Rie)  ) and manner as diplace, and due	utopsy findings availated completion of cause as 2 No No Northy)  ural Route Number, as stated. Set of the cause(s)

			For State Registrar	State of	Marylar		artmeni rtificate			ınd M	ental Hy	ygiei Reg.	201	34	01	271
	Physicia		1. Decedent's Name (First, Middle Elizabeth	G. Ward							2. Date of D Month Jan.		Day 2004	ear	3. Time	
	/Medic Examin		4a. Facility Name (If not institution Fairland Nurs			er	Sil	ver	Sprin	ng			4c. County of Mont		∍ry	
Z.C.	Funeral Director		5. Social Security Number 206–32–5858	6. Sex 7 1 ☐ M 2 🌠 F	. Age (In yrs. 9	last birthday)  5 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D Sept. 2	irth Pay, Ye , 19	08 Pe	Coun	lace (State ltry) Sylvar	or Foreign nia
	Maryland -f show lind at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Princ	e George's		y, Town or Lo					_			1	0d. Inside	City Limits
	n with the	Direc	10e. Street and Number 3607 Chase Ter			<u> </u>	10f. Zip	Code 2070	5			10g.	Citizen of What			
920	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show of cal Expeditute must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Marr  3 Nidowed 4 Divorced	12. Was Deced Armed Ford ied 1 Tes 2 If Yes, Give Year or Dat	es? L <b>X</b> No	}	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	lo-	14. Race -	Americ White,	an Indian,	
21215-0036	S	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12	college (1-4	4or 5+) 1 <b>– 4</b>	(Give	dent's Usua kind of woi DO NOT us maker	l Occupa k done d se retired	ation furing most )	of workin	g	16b	Kind of Busin			
Maryland 2	2 should be filed with and Mental Hygiene is marked other tha aumatic event, Illel	To Be Co	17. Father's Name (First, Middle, David H. Geo:	Last)	1-4							law:	len Sumame)	ione		
	12 E E		19a. Informant's Name/Relations Beverly J. Ward			3607	Chase	Tei		Belt	sville	e, N	yorTown,Sta Marylan	d 2	0705	
Baltimore,	80 = 30		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S			Place of Dispo cometery, cre- kland (	matory or of Cemete	ther plac ery	1,	/29/2		Inc	Location - Ci	enn	sylva	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Bozera	rdt		nald 100 Pc	d Addres V I Wdei	Sorgwand Mill	ardt I Roa	Funera d Beli	al I Esvi	Home, F Ile, M	A. lary		
	Physician /Medical		23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Cor	ngestiv	ve Hear				cardiac oi	respiratory	arrest,			Approximation Interval Bookset and	etween
	Examiner	er	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury	b. Rer	ras a consec nal Fai	lure										
8760,	ate be executed hysicien and the burial-transit	dical Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0.	r as a consec											
.O. Box 68	The law requires that the death certificat to has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2∏ Feta ntattime of d	al death 3	Ectopic pr					2	23d. Date of Month		ory Day	Year
rds, P	puires that n signed b	þ	Part II. Other significant condition	ons contributing to dea	ith but not res	sulting in the u	inderlying c	ause give	en in Part I.				o use contribu		ne cause of ably 4	
il Records,		Completed									24a. Waa auto per 1 □ Yes	opsy formed	? prio	r to cor th?	psy finding npletion of 2 \( \text{No} \)	s available cause of
f Vital	Physician: The this certificate har director, page	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ XNo	Hospital:	patient 2	]ER/Outpatie	nt 3 DC	Othe	ar		(Check only		6 □Other	(Specify	()	
ion of	ding After fune		27. Manner of Death  1 Natural 5 Pendir 2 Accident investig	gation	Injury , <i>Day Year)</i>	28b. Time o Injury	f 2	8c. Injury Work 1 📋	rat k? Yes 2 □ t		8d. Describe	how in	njury occurred			
Division	tal or Attankrs after deatles Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 289. Place C	f Injury - At h g, etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory	, office		2	8f. Location City or To		and Number ate)	or Rura	l Route Nu	mber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai		g Physician: To the b Examiner: On the bas and manne	is of examina											o(s)
	To the To the comple	ž	29b. Signature and title for rtifie		45	sigl	290	D45	660				Date signed (/ January			
	'	13	30. Name an Address of person Dpinder Singh					ne, #	124 E	3owie	, Mary	/lan	d 2071!	5		
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Sign	ature	Sp	als						-		

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician use as the signed by the a detached To the Hospital or Attanding Physician: funeral After Director: within 24 hours after To the Funeral Direct 30

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

Examine

by Physician/Medical

Be Completed

Certification: To

Medical

State

Registrar

JAN 28 2004

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than \*natural', or items 23a or 28a-1 show any injury grother traumatic avent. The Mudical Exercitive Lives to notified at once.

Physician

Examiner

/Medical

burial-transit

Baltimore, Maryland 21215-0036

			1 - For State Registrar	State of I	Maryland		artment			nd M		iene eg. No.	200	-	04276
	Physici /Medio		1. Decedent's Name <i>(First, Middle, I</i> LOIS	.ast)	W	ſ		WILS	SON		2. Date of Dea Month JANUA	Day	Yea 18 20		3. Time of Death  1330 M
Y	Examir		4a. Facility Name (If not institution, g CHESTER RIVER		•	ER	1		ocation of				County of De		
	Funeral Director				Age (In yrs. last 70	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day) Peb. 1,	Year) 193	(	<i>country</i>	ce (State or Foreign 1) 1vania
	aryland show det	Ļ	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	ocation								I. Inside City Limits
	the Mi	recto	MD. Kent	<u> </u>	Che	ster	town	Code			1	0a. Citiz	en of What (	Country	1 X Yes 2 □ No
	1h with 23e ou	alDi	101 Morgnec Ro	ad Apt. J	102		21	.620					USA	,	
920	72 hours after death with the Maryland insturel; or items 23e or 28e-1 show digal Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? XNo		Was Decedif Yes, spec		panic Origi , Mexican, Specify:	in? (Spec Puerto R	city Yes or No- lican, etc.)		4. Race - An Black, Wh Specify:		D
215-003	ithin 72 ho ne. nan "netur Medical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4c		(Give life.	dent's Usual kind of word DO NOT use	к доле ди	ion ring most	of workin	g	16b. Kin	d of Busines		
d 21	iffed within I Hygiene. other than ent, Ita Me	Co	12th 17. Father's Name (First, Middle, La	<u>4</u>		Tea	acher	1	8. Mother	s Name	(First, Middle, M			ry	Education
ylan	2 should be and Mental is marked c	To Be	Robert T. Wil	.son					Ιċ	la Ar	derman				
Maryland	T = N =		19a. Informant's Name/Relationship								Route Number				
ce,	es 1 and of Health fitem 27 r other tr		Calvin Wilson		20b. Place		Sition (Nam matory or oti			Da Da			ation - City o		Id. 21620
altimore,	permit. Pages Department of Importent: if it any injury or o		1 ☐ Burial 2 🛣 Cremation 3  `4 ☐ Donation 5 ☐ Other (Spec	cify)	10	apeak	ke Cre	mato	ry¦1	./19/	2004	Steve	ensvil	1e,	Maryland
Ba	Depar Impor any ir		21. Signature of Funeral Service Lic	Helfy	Le	1	PITOWS 30 Spe	, He er R	Ifentoad,	ein Ches	& Newna	am Fi	uneral arylan	Ho d 2	me, P.A. 1620
	nysician	0 1	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cassiti (Final	mplication that caus ly one cause on each A	1 11110.	Do not ent	er the mode	of dying,	such as ca	ardiac or	respiratory arre	est,		A In O	pproximate terval Between nset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or a	as a consequen		1							'	Jans
		ner	Sequentially list conditions,		uep hend as a consequen		isiula	<u> </u>	Isean	e					Years
	be executed sician and burial-transit	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		umo = id		, thi	45				_	_	,	years
68/60	icate be ex physician s the burial	edical		d. Con	-	an	, d	isea	si	_				Ŀ	years
O. Box	Ine law requires that the death certificate tie has been signed by the attending phys bage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	ath 3	Ectopic pre Other (spe					23	id. Date of de Month	olivery Da	y Year
rds, P	w requires that s been signed b should be deta	þ	Part II. Other significant conditions Breast Cance	contributing to death		g in the ur	nderlying ca	use given	in Part I.						eause of death?
Vital Records,	Ihe law re ate has bee page 2 sho	Completed		Ranine		-					24a. Was ar autopsy perform	ed?	prior to death?	compl	findings available letion of cause of
		Be C	Osteo porosis 25. Was case referred to medical examiner?								1 ☐ Yes 2 Check only one	)	1 🗆 Ye		
10 C	ng Phys fter this meral di	2	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: Inpa  28a. Date of In (Month, L		Outpatien  D. Time of Injury	t 3□ DOA 28	c. Injury a Work?	4 □ Nurs t s 2 □ No	28	e 5 Reside			ecify)	
DIVISION	I o the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of I	njury - At home, etc. (Specify)	, farm, stre	eet, factory,			-	f. Location (Str City or Town		Number or F	ural R	oute Number,
	ne Hospil n 24 hour he Funere	edical	29a. Certifier Certifying F (Check only one)	Physician: To the bes aminer: On the basis and manner	of examination	ige, death and/or inv	occurred at restigation, i	t the time, n my opin	date and lion, death	place, an	d due to the ca I at the time, da	use(s) a te and p	nd manner a lace, and du	s state	d. e cause(s)
	To I	Σ	29b. Signature and title of certifier					License n		_	29	d. Date	signed (Mon		r, Year)
			30. Name and address of person who	o completed cause of	death (Item 23)	a) (Type.		- 007	5947	40		1/	19/0	4	
			Dr. David Anto	nio Cosenz	za 100 H	Brown	Stre	et, (	Chest	erto	wn, Mar	ylar	nd 216	20	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 0	2004 32. Ro	strars Signature	× A	book	9							

				1_ For	State of M	aryland / Depa	artment of H	Health and M	•		01077
	_			Registrar		Cei	tificate of	Death		1. No. C U U 4	14611
	п	Physici	ian	Decedent's Name (First, Middle     Tato A NECTRO		טר זור זו	T TACITION	CIZT	2. Date of Death Month	Day Yeer	3. Time of Death
		/Medi		FRANCES  4a. Facility Name (If not institution	TILLE	I WIE	Ab City Town	or Location of Death	JAN G	25 2004 4c. County of Deeth	12:30 PM
		Examir	ner	MARINER		ALI AID	BEL			HARFO	00
		Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birthp	place (State or Foreign otry)
		Director	ŀ	216-03-5714	1□ M 2 <b>)</b> F	90 Yrs.	Months Days	Hours Min.	4/22/1	913 Mar	yland
		and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			1	0d. Inside City Limits
		Maryl	tor	MD. H	Harford			Bel Ai	r		1 ☐ Yes 2 No
		n the	lrec	10e. Street and Number		1	10f. Zip Code	202 112		g. Citizen of What Cour	ntry?
		23a c	Funeral Director	821 Sider	mill Drive			21015	U	nited St	ates
		tems	nue	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of his Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
	36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 M Widowed 4 ☐ Divorced	# Vac Give	No .	I□Yes 211 No	Specify:		Specify: 14F	hite
	9	2 hou ature	ted	15. Deceden	it's Education	16a. Deced	ient's Usual Occup	pation	16	bb. Kind of Business/Inc	
	215	thin 7	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5	life. /	kind of work done OO NOT use retire	during most of working)	ng		
	21	ygien ygien her th		5	0		Homemal			Home	
	and	ntal H ed ot	Be	17. Father's Name (First, Middle, Michael	Last)	Manainal	4	18. Mother's Name	(First, Middle, Ma		- 7 7-2
	Maryland 21215-0036	should od Me mark matic	2	19a. Informant's Name/Relations	thip (Type, Print)	Mrozinsk		Mary Mary	I Route Number C	Chml.	elewski
	Ma	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Exertified at		Frances M. Mo						Air. Md	•
3	ore,	of Head		20a. Method of Disposition		20b. Place of Dispos		_		c. Location - City or To	
Jen Go	Ë	Page ment o ant: If ury or		1  Burial 2  Cremation  4  Donation 5  Other (S			f Faith			sedale, 1	Marvland
3	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f ehow important: If item 27 is marked other than "naturel", or items 23e or 28e-f ehow pay injury or other traumatic event, it is Medical Exertified at ODICE.		21. Signature of Euneral Service	Lighte 5	1/27 22	. Name and Addre	ess of Facility Ja:	rrettsv	ille, Ma	ryland
V		40304		222 Bart Fotor the disease of	HELDAN / WAR					al Home,	
				23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Finaf	only one cause on each li	the death. Do not ente	21	1/ /			Approximate Interval Between Onset and Death
	1	Physician /Medical		disease or condition resulting in death)	a. Que to or as	a consequence of):	em c	Mean	<u> </u>		Traff
/	7	Examiner			1	a consequence on.					
٨		<b>v</b> =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
		eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
	760,	be ex ician burial	cal E	<b>3 3</b>	Due to (or as	a consequence of):					
. }	687	ficate physis the			d						
7	Вох	n certi	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	rv
3	Ö.	ne death the atte	sicla	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		Ectopic pregnancy Other (specify)	/ 		1	Day Year
5	P.0	that the d ed by the detached	Physiclan/Med	9 □ Unknown	9□ Unknown	184					
5	S,	res tha signed be del	þ	Part II. Other significant condition	ons contributing to death be	ut not resulting in the un	derlying cause giv	en in Part I.		co use contribute to th	
3	Record	v require been si should t	Completed		1 acers	1 coccur			1 🗆 Yes	2k No 3 Proba	ably 4 🗍 Unknown
3	3ec	has b	шр						24a. Was an autopsy performed	prior to con	osy findings available apletion of cause of
77	a	icien: Th certificate rector, pag	e Co	OF Mos soon referred to medical					1 □ Yes 2 ☑		20 Mo
3	Vital	ysicien: The is certificate hadirector, page	0 B	25. Was case referred to medical examiner?  1 □ Yes 2√2/No	Hospital:	nt 2 ER/Outpatient	3□ DOA Oth	er: 4 Nursing Hom		e 6 Other (Specify	
	J Of	g Phys ter this neral di	<del> </del>	27. Nanner of Death	28a. Date of Injur		28c. Injun		8d. Describe how		)
	joi	utending I death. ctor: After y the funer	atlo	Natural 5 Pendin investig	gation	Year) Injury		Yes 2 □No			
	Division	or Attendated death Director:	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 28e. Place of Inju- building, etc	ry - At home, farm, stre :. (Specify)	et, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
		pita nurs arel		29a. Certifier 10 Certifyin	Bhusiaine. To the book						
		To the Hos within 24 ho To the Functional Completely f	Medical	(Check only 2   Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or inv	estigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
		To the within To the comple	Me	29b. Signature and tipe of certifier			29 License	e number	29d.	Date signed (Month, L	Day, Year)
	•			> Irch	Me		DS	8039	DA	WVARY 26	2004
		7		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type, f	77144	De lara.	Rell	An-MO	MAIT
			• 0	31. Date filed (Month, Day, Year)	132 Ranie	ar's Signature	WITTE	TUVON	1-41	VIII	70.5
		Sta Registr	_		2 9 2004	alice H	brast ?	(			

or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, this within 24 hours aftar death.

To the Funeral Director: Af To the Hospitai

Pages 1 end 2 should be filed within 72 hours after death with the Maryland nant of Health end Mentel Hygiene. Int: If Item 27 is marked other than "naturel; or Items 23e or 28e-f show

Baltimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

Panc

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

29c. License number

		-	For State Registrar	State	of Ma	aryland i		artment <i>tificate</i>			nd Me	ental Hyg	jiene 1eg. No.	2004	04279
	Physici	20	1. Decedent's Name (First, Middl	_			•					2. Date of Dea	Day	Year	3. Time of Death
	Physicia /Medic	al	Mario Ant					45 O'5 7		Location of		Februar		2004 County of Deat	9:45 AMM
	Examin	er	4a. Facility Name (If not institution Charlestown	-					nsv:		Dealli		40.	Baltin	
Ī	Funeral Director		5. Social Security Number 057–16–1567	6. Sex 1∭ M 2□ F	_	e (In yrs. last 83	birthday) Yrs.	If Under 1 Months	Year Days	If Under 2	Min.	8. Date of Birth (Month, Day Jan 11	, Year)	9. Birti Co New	nplace (State or Foreign untry) York
	<u> </u>		Usual Residence of Decedent			10c. City, T									10d. Inside City Limits
	show	5	MD Balt	imore		•		ville							1 ☐ Yes 21 No
	28a-f	Director	10e. Street and Number					10f. Zip	Code				10g. Citiz	zen of What Co	untry?
	death with the Maryland ms 23a or 28a-f show finust be notified at	a D	709 Maiden Cho	ice Lane					2	1228				USA	
õ		y Funerai	11. Marital Status  1 Never Married 2 Mar	ned 1 X Yes	Forces? s 2∐N Give		i	Was Decede f Yes, speci		spanic Origin, Mexican,  Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)		14. Race - Ame Black, White Specify: W	
12-003b	hours turel',	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:	WW II	6a Decer	dent's Usual	Occupe	tion				nd of Business/	
Ċ	within 72 hours after ene. than "naturel", or Ite he Medical Examina	Completed	(Specify only higher	st grade complete	d) (1-4or 5		(Give	kind of work DO NOT use	done di	uring most (	of workin	g	100.11	id or buomosa	
7	d with	Eo	12	_	+	"	е	ngine						electri	cal .
and	uld be filed Mental Hygi irked other itic event, II	Be	17. Father's Name (First, Middle,									(First, Middle,		Sumame)	
>	2 should the and Ment is marked aumatic	ဥ	Enrico Anto				19h Mailir	a Address	(Street a			Schirru Boute Numbe		r Town, State, 2	in Code)
ă Z	th and 2 st		Bobbi Jensen/					•							ip code)
Baltimore,	Pages 1 and 2 should been of Health and Mentent: If item 27 is marked iry or other traumatic e		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (5	3 ☐Removal fro		cemi	e of Dispo	sition (Nam matory or oti	e of			ite ,		21205 cation - City or	Town, State
Balt	permit. Page Department of Importent: If any injury or once.	İ	21. Sonature of Funeral Segrice	Wade,	-		St	Name and ate A lltimo	nato	my Bo	ard 1201	655 W.	Ba1	timore	Street
I	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause or	n each lin	the death. (	Do not ent		<del></del>			respiratory ari	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,			a consequen									1.000
	be sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o (or as	a consequen	ce of):								
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as	a consequen	ce of):	-							
8/60,	ysicial	dicai		Ld											
٥	rtiticat ng phy s as th	Medi	IF FEMALE:	11AS											
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transif	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1□Liw	birth gnant at	of pregnancy 2 Fetal de time of deatl	ath 3	Ectopic pre Other (spe					2	3d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	<u>م</u>	Part II. Other significant conditi	ons contributing to	death be	ut not resultir	ng in the u	nderlying ca	use give	n in Part I,			bacco u es 2[		the cause of death?
Records,	ysicien: The law requires that iis certificate has been signed b director, page 2 should be deta	Completed										24a. Was a autop perfor 1 Yes	sv	prior to d	topsy findings available completion of cause of
Vıtal		Bec	25. Was case referred to medica examiner?								of Death	(Check only or	10)		
	Physic this or	ဥ	1 ☐ Yes 2 No		Inpatie		/Outpatier		-	4 Invurs		e 5 ☐ Resid 8d. Describe h		Other (Spec	cify)
00	ding h. h. After funer	tion	27. Manner of Death  1 Natural 5 Pendi 2 Accident invest	ng (Mi igation	te of Injui	y Year)	b. Time of Injury	M	Sc. Injury Work 1   Y	at ? ′es 2 □ N		Bd. Describe II	ow stijury	yoccurred	
Division of	i or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 200. Piz	ice of Inju	ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory,	office		2	8f. Location (S City or Tow			ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.	edical C		ng Physician: To Examiner: On the and m		examination									
	To the comp	Σ	29b. Signature and title of certific	er -					License					e signed (Montl	•
			Themes	/				T	2E C	989			Fak	50 0	4005
		•	N. 19	who completed ca	M	eath (Item 23 ar's Signature	Ba) (Type,	Print)	en	Cho	) i C	z Lar	x (	Cotton	2004 SVIVE MD
	Sta Registi		FEB 12	2004	Delet	as M	A	34							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3-20 PM FEBRUARY 07 Joseph W. Adlam 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 6, 19 Birthplece (State or Foreign Country) Funeral 1⊠M 2□F 80 Yrs. Director 219-18-9732 Illinois Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Medical Examiner must be rediffied at MD Anne Arundel Glen Burnie 1 ☐ Yes 2√ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Main Avenue SW 21061 USA 14. Race - American Indian, by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineer electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Richard Adlam Elsie Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau Betty Lee Adlam/spouse 219 Main Avenue SW Glen Burnie, MD Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 ☐ Other (Specify) 21. Signature of Ronal Constant Wade, Director permit. State Anatomy Board 655 W. Baltimore Street mum/1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EXACERBERATION OF CHRONIC LUNG DISEASE ACUTE **Physician** Iweek /Medical OBSTRUCTIVE PALMONARY DISEASE 20 YEARS Examiner HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. I 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by GASTRO INTESTINAL 1 2 Yes 2 No 3 Probably 4 Unknown page 2 should DYSPHAGIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? MALNUTRITION 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No ours after death.

lerat Director; After this certific
filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerat I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ar, 4.D. 46962 D FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21061. ARUNDEL HOSPITAL. NORTH M. SHIRAZI, M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 1 2 2004

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 1 - For State Ragistra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mon Year 004 **Physician** 1345 PM 00 /Medical County of Death 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner Baltimore land Ned (1+ niveral 0 If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) It Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 XM 2 ☐ F 49 MARYLAND Director 219-60-8382 AUG 20 1954 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28e-f show the Medical Examinar must be notified at 1 X Yes 2 □ No **Funeral Director** BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4319 ELDONE ROAD 21229 U.S.A. death or Itams 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene Important: If New 27 is marked other than "natural;" or Itan any injury or other traumatic event, tra Mudical Feedomes. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK Be Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th grade FLOOR TECH AIRPORT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES BERRY JR ARTCHIE BELL EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4319 Eldone Road, Baltimore, Jacqueline Larkins/Niece Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-16-04 MT ZION CEMETERY LANSDOWNE, MARYLAND william C Brown Community Funeral Home P.A. harles 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ntracrania **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (dr as a consequence ot): Completed by Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence ot) P.O. Box 68760. physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After To the Hospitel or Attending 5 Pending investigation 1 Alatural nours after death.

neral Director: Aft
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 125-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 8 M.D 2004 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) By Himore South Heven 2120 Weinsier eene 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2004 Registrar FB

awn	DOSTO	11		State of Maryland /	Department of Health and M	lental Hygien	e2004	04282
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. No.	o	3. Time of Death
	Physicia /Medic		Shawn !	Boston			o6, 2004	21:10 M
	Examin		4e. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	44	c. County of Deeth	$\triangle$
	Funeval		2700 block Eager S  5. Social Security Number 6. Sex	treet 7. Age (In yrs. last bi	Baltimore  rthday)   If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthpl	ace (State or Foreign
14	Funeral Director		21386-6619 /	M 20 F 32	Yrs. Months Days Hours Min.	(Month, Dey, Year		m MO
land	M II		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	m or Location		10	Od. Inside City Limits
May	the difference	ctor	MD N	IA	BAltimore			1 Xes 2 □ No
with the	be no	Funerai Director	10e. Street and Number	Place	10f. Zip Code	10g. C	itizen of What Count	try?
death	ms 23.	nerai	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
-0036 hours after death with the Maryland	jene. r than "natural", or Items 23a or 28a-f show It a Medical Examinar must be rutified at	by Fur	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	nican, etc.)	Specify: Specify:	ac K
	atural cal Ex	led b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	ation 16a	. Decedent's Usual Occupation	16b. I	Kind of Business/Ind	lustry
21215-0036	Medi	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	all Pr	starol
	T S E		17. Father's Name (First, Middle, Last)		CONSTRUCTION 18. Mother's Name	e (First, Middle, Maide		1
arylan should be		To Be	Charles Bo	ston	ARLI	TA ALR	BRITTON	
Maryland	PEE		19a. Informant's Name/Relationship (Type		b. Mailing Address (Street and Number or Run 1756 Roth & Now	Al Route Number, City	or Town, State, Zip	4 41
-	f Healt item 2 other		20a. Method of Disposition	20b. Place		Date 20c. I	Location - City or Tov	
imor			1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Med	ro Crenatry 2-11	004 M	ARy 1A	Om
Baltimore,	Department Important: I any injury o		21. Signature of June al Service Lifense	in hour th	22. Name and Address of Facility	Well H	merel 1	Town
£	1		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest.	D.1145	Approximate Interval Between
ρ	nysician		Immediate Cause (Final disease or condition	Multiple	sunshot wounds			Onset and Death
100	/Medical xaminer		resulting in death)	Due to (or as a consequence	of)			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of).			
polito	and I-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):			
Box 68760,	ohysician and the burial-transit	cal E						
.89	ing phys		IF FEMALE:					
Box	attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	ry Day Year
P.O.	by the a	hysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown				
S a	signed I	þ	Part II. Dther significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.	il in the second	use contribute to the 2 X No 3 ☐ Proba	e cause of death?
Record	been si	Completed				24a. Was an		osy findings available
Re	ate has	фшо				autopsy performed?	prior to con death?	npletion of cause of
of Vital		BeC	25. Was case referred to medical examiner?	ospital:	0.0	h (Check only one)		
o d	this ral dir	: To	1√ Yes 2 No Path	28a. Date of Injury 28b.	Time of 28c. Injury at	me 5 Residence 28d. Describe how inju	ury occurred	,
vision	death. ctor: After y the funer	ation	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day Year) 2-6-04 9=	ou PM 1□Yes 2KNo	Subject	was sh	701
Division	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, in building, etc. (Specify)	. 1 6	28f. Location (Street a City or Town, Sta	10) 2700 bi	Route Number, K Eager Stre
ا اوارد	within 24 hours after To the Funeral Directory (illed in b		29a. Certifier 1 Certifying Phys	Inside a car on	e, death occurred at the time, date and place,	and due to the cause(	s) and manner as sta	ated.
i ede	the Fu	Medical	one)	er: On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occur			
,	Son Twit	-	29b. Signature and title of certifier	m. D	29c. License number O.C.M.E		oruary 07,	
	Y		30. Name and address of person who co		(Type, Print)	2 52	_	
				h ( )	111 Penn Street, Bal	timore, Mai	ryland 212	201
*	Sta Regist		31. Date filed (Month Day Bear 2 2	32. Registrar's Signature	Angula)			

		1	State of Maryland / Department of Health and N  - State of Maryland / Department of Health and N  - State of Maryland / Department of Health and N  - State of Maryland / Department of Health and N  - State of Maryland / Department of Health and N   Certificate of Death	ientai Hyg	g. No.	04283
	Physicia		Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death 4:00 PM
	/Medic	al -	Lawrence Anthony Bender  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Februar	y 5, 2004 4c. County of Deat	
	Examin	er	St. Martins-Little Sister of the Poor Catonsville		Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year of Under 24 Hrs. Age (In yrs. last birthday)	B. Date of Birth (Month, Day, November	9. Birth Co 14,1924 M	nplace (State or Foreign untry) aryland
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Maryl ind	tō	Maryland Baltimore Catonsville			1 ☐ Yes 2 ☑ No
	death with the Maryland	Funeral Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	
	s 23a	erai	603 Maiden Choice Lane 21228  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	U.S./ 14. Race - Ame	
2-0020	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene is the firm 27 is marked other than "natural", or liems 23a or 28a-f show item 27 is marked other than "natural", or liems 20a or 28a-f show other traumatic event, the Medical Eventhal minut be collided at	þ	11. Marital Status  1	Rican, etc.)	Black, White	*
D-C12	within 72 ho ene. than "natur ta wedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ing	16b. Kind of Business/	Industry
Ž	e filed wit Il Hygiene other the		5+ Roman Catholic Priest  17. Father's Name (First, Middle, Last)  18. Mother's Name	a (First Middle I	Church	
yland	d be fi	To Be	Frederick S. Bender Barba			Ploor
C.	2 should be and Mental is marked aumatic ev	F	19a. Informant's Name/Relationship (Type, Print)  Fellow  19b. Mailing Address (Street and Number or Rur	al Route Number	City or Town, State, 2	Zip Code)
, Ma	and 2 lealth a m 27 I		Rev. Ronald D. Witnerup- Priest 5408 Roland Avenue 1	Baltimor	e. MD 212	
TOTE E			cemetery, crematory or other place)		Bryantow	
Baltimore,	permit. Page Department of Important: If any injury or once.			Baltimor	e, Marylan	d 21214
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death I Weeli
	/Medical Examiner		Due to (or as a consequence of):  Double to (or as a consequence of):  Double to (or as a consequence of):	0		TATION
	L. F.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			7
	and transit	Examiner	Cause (Disease or injury that initiated events c. essulting in death) Last Due to (or as a consequence of):			
58760,	icate be executed physicien and s the burial-transit		bus to (or as a consequence or).			
_		Medical				
.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   1   1   1   1   1   1   1   1   1		23d. Date of de Month	livery Day Year
О.	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	he law require a has been si ige 2 should b	Completed		24a. Was a autop perfor	sv prior to	utopsy findings available completion of cause of
	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical 26. Place of Dea			22.10
> <	ding Physician: The In. After this certificate ha funeral director, page	2			ence 6 Other (Spe	ocify)
ouo	ding P. h. After i tunera	tion	27. Manner of Death  1 ★Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 ★Natural 5 Pending investigation  M 1 Yes 2 No	28d. Describe II	ow injury occurred	
Division of Vital	To the Hospitel or Attendation 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	Hospite 24 hours Funere	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and or investigation and occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and occurred at the time, date 2 Medical Exeminer: On the basis of examination and occurred at the time, date 2 Medical Exeminer: On the basis of examination and occurred at the time, date 2 Medical Exeminer: On the basis of examination and occurred at the time, date 2 Medical Exeminer: On the basis of examination and occurred at the time, date 2 Medical Exeminer: On the basis of examination and occurred at the time, date 3 Medical Exeminer: On the basis of examination and occurred at the time, date 3 Medical Exeminer: On the basis of examination and occurred at the time, date 3 Medical Exeminer: On	and due to the orred at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 3	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	
			Narkaran 021649		tel 6,	2004
			30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)  S. BAKARA, 3455 W.LK. EW. AVE, BALTIM.	ORE 1	MD 212	29
7	St Regist	ate rar	31. Date filed (Morth, Day, Year) 104 32. Registrar's Signature			,

State of Maryland / Department of Health and Mental Hygiene 2 🛭 🕦 👢 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0010 Geraldine Romaine Brooks February 10,2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/AUnion Memorial Hospital If Under 1 Year If Under 24 Hrs.

Pays Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖸 F 83 Yrs. 215-07-7499 Nov. 7,1920 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County \*OHe r than "natural", or Iteme 23s or 28s-f sho the Medical Examinar must be notified at XXYes 2 No Maryland N/ABaltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3838 Roland Avenue Apt. 903 USA 21211 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural, or Iten any injury or other traumatic event, the Medical Emericanons. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify: Specify: white þ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George E. Krixer Emma Yingling ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine Laucht 4307 Grandview Avenue Baltimore, Maryland 21211 (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 2/14/04 Elkridge, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which Court Time. 21211 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure seven years /Medical Due to (or as a consequence of). Examiner Artery Disease Seven years Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed inding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2.X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Impatient Other: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Cheschles MD AT 2438946 D9 February 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 201 E University Parkway; Baltimore, atherine Meschlere; 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 1 2 2004

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 9, 2004 **Physician** BLANK 11:45 AM LILYAN /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) DEC. 21, 1910 Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 ☐ F Director 060-32-3075 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show in than "naturel", or items 23a or 28a-f show the Medical Examiner must be nytified at 1 Yes 2 No Director COLUMBIA MD HOWARD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 U.S.A. 10354 CROSSBEAM CIRCLE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (A) No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or item any injury or other traumatic event, its Medical Essen 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕷 No WHITE Specify: Specify. ۵ Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME **HOUSEWIFE** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ABRAHAM ROTHENBERG YETTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10354 CROSSBEAM CIRCLE - COLUMBIA, MD 21044 DAVID BLANK / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 X Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MT. ARARAT CEMETERY 2/11/2004 FARMINGDALE, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): weeks /Medical Examiner Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit 5- 6161 and Due to (or as a consider ence of) Division of Vital Records, P.O. Box 68760, the attending physicien Advenica the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by pe 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No certificate 1 ☐ Yes 2 NO Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and attle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053636 9,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia CARCSON MO charles Drive 10700 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Boach

**ORIGINAL** 

			1 - State Unpend Item #23	State of Na,27,28a-f	Marylar per me	nd / Depa G828 <u>പ്</u> ക്	artme	nt of H Ite <sup>S</sup> of L	ealth a D <i>eath</i>	and M	lental Hy	giene Reg. No	20	] [	04286
	Physici		Decedent's Name (First, Middle, La JOH		EVA	N	BE	ARMAN			2. Date of De Month Februa	Da		'ear 004	3. Time of Death 21:10
	/Medio Examir		4a. Fecility Name (If not institution, gir	ve street and number				y, Town, or	Location	of Death			. County of		21.10
0		•	2709 Cheswolde Av	venue			Bá	altimo	ore						N/A
	Funeral Director			Sex 1 M 2 □ F	Age <i>(In yr</i> s. 31	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MAR . 13	th ay, Year, 3,19	72	9. Birthp Cour	lace (State or Foreign htry) MD
	po ,		Usual Residence of Decedent  10a, State 10b, County		100 0	ty, Town or Lo								1	Od. Inside City Limits
	anyla	2			100.0			\_						- [	1  Yes 2 No
	the M	Director	MD N/A  10e, Street and Number	-		BAL	TIMO	KL Zip Code				10a Ci	tizen of Wh	at Cour	Λ
	with	ក		VENUE			101.2	ip Code	212	กด		log. O	MEGIT OF THE	at 0001	U.S.A.
	heeth	era	2709 CHESWOLDE A	12. Was Decede	nt Ever in U	J.S. 13.	Was Dec	edent of Hi	ispanic Or	igin? (Spe	ecify Yes or No	o- T	14. Race -	Amend	
36	within 72 hours after deeth with the Maryland ene. then "natural", or items 23e or 28e-f ehow ta Mudical Exertiner man I've molified at	by Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1  Yes 2 [ If Yes, Give ' Year or Date:	No		If Yes, sp		n, Mexicai Specify:		Rican, etc.)		Black, Specify:	White,	etc. WHITE
21215-0036	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's U	sual Occupa	ation			16b. k	(ind of Busi	ness/In	dustry
215	nin 7.	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4c	or 5+)	(Give	DO NOT	vork done d use retired	luring mos ()	st of worki	ng				
21	giene giene er the	Completed	Elonionally Coloridaty (o 12)	2		BANI	KER								MORTGAGE
pu	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Las	1)					18. Moth	er's Name	(First, Middle	, Maidei	n Sumame)		
Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If Item 27 Is marked other than "nature or othar traumatic event, Its Mudical	2	SHELDON				RMAN			RLEN		E			RLICH
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship SHELDON BEARMAN				-				I Route Numb ERVILLE				Code)
	of Health Item 27 other tra		20a. Method of Disposition	/ IATILK		Place of Dispo	osition (A	ame of			ate		ocation - C		wn, State
Baltimore,	Pages nent of I ant: If Its ary or o		1 X Burial 2 Cremation 3 ( 4 Donation 5 Other (Special		te	cemetery, crei THELN	- 1000			2/11	/2004				
Ħ			21. Signature of Funeral Service Lice		DL			and Addres			/ 2004				WN, MD .EVINSON &
Ba	permit. Departi		May	ix		В	ROS.	. TNC	- 89	100 RI	EISTERS	TOW			21208
The same			23a. Part1. Enter the disease, or construction shock, or heart failure. List only Immediate Cause (Final			th. Do not en	ter the m	ode of dyin	g, such as						Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition / resulting in death)	g	as a conse	Cocaine	into	xicati	.on					-	
п	Examiner			b											
	_ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):									
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (ex											
8760,	be ex cian a	ai E	Todaking in double, but	Due to (or	as a consec	quence or);									
87	physi the b	dicai	•	d											-
9 X	eath certific attending p	/We	IF FEMALE:	23c. If yes, outcor	ne of pregn	ancy							23d. Date	of delive	arv.
Вох	atter of for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			⊒Ectopic ⊒ Other (	pregnancy specify)					Month		Day Year
o.	that the de ted by the a detached t	hysl	9 Unknown	9 Unknown	1										
G,	The law requires that the death certift tie has been signed by the attending page 2 should be delached for use as	by P	Part II. Other significent conditions	contributing to death	but not res	sulting in the u	ınderlying	cause give	en in Part I	١.	23e. Did t	obacco	use contrib	ute to th	ne cause of death?
ord	w require been sig should b	ed									10	Yes 2	DENO 3	Prob	ably 4 Unknown
Records,	has be	Completed									24a. Was	psv			psy findings available mpletion of cause of
R		Con									Yes perfe	ormed? 2 ☐ No	de	athr?	2 No
Vital	lysician: Th	Be	25. Was case referred to medical examiner?								Oneck only				
of	Z	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpaties			4 🗀 191		me 5 Resi				SCENE
no	Jing I	Certification:	1 □Natural 5 □ ending	28a. Date of I	Day Year)	28b. Time o	М	28c. Injury Work	Yes 2X	1	28d. Describe		iry occurred	1	
Division	l or Attending after death. Director: After I in by the fune	lical	3 ☐ Suicide 6 🗶 Could not	2/9/04	Injury - At h	Unknown	1				Unkno 28f. Location (		nd Number	of Rura	il Route Number,
Ω	after after Dire	erti	4  Homicide determined	building, Home	etc. (Speci	fy)	,	,,					e) 2709	unes	Wolde Ave.,
	Hospital 24 hours ( Funaral itely filled		29a. Certifier 1 ☐ Certifying P	hysician: To the be	st of my kn	owledge, deat	h occurre	ed at the tim	ne, date ar	nd place, a	altimore	cause(s	and mann	er as s	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medicai	(Check only 2 Medical Exa	miner: On the basis and manner	s of examination	ation and/or in	vestigati	on, in my or	pinion, dea	ath occurre	ed at the time,	date an	d piace, an	d due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0 1.1			2	9c. License	number			29d. Da	te signed (	Month,	Dey, Year)
			( 9 00	herry				0	.C.M.	E		Fe	bruar	y 10	, 2004
			30. Name and address of person who	completed cause of	death (Ite	3a) (Type,									
			31. Date filed (Month, Day, Year)	32 Ban	strar's Sign		Pen	n Str	eet,	Balt	imore,	Mar	yland	212	201
	Sta Regist		FFR 1 9 2004	Ara De	االوات و المالت م	6	1								

Division of Vital Records, P.O. Box 68760,

			State of	Marylan		rtment of I tificate of		Mental Hy	giene Reg. No. 20	04	04287
		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month		Voor	3. Time of Death
Physicia /Medic		THOMAS CHA	RLES CAN	NON			_	FERRU	MRY 3	2004	2:45PM
Examin		4a Facility Name (If not institution, g	ive street and numb	oer)			4b. City, Town, or	Location of Death	4c. County	of Death	
		STELLA MARIS AT	MERCY HO	SPICE			BALTIMO			I/A	
Funeral		Social Security Number     6.	Sex 7. 12XM 2□ F	. Age (In yrs. I		If Under 1 Year Months Days			th y, Year)	9. Birthpla Countr	ace (State or Foreign
Director		217-38-8443	10 m 201	- 6	2 Yrs.			OCT 26	5 1941	NORT	H CAROLINA
₽	ł	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation				10	d. Inside City Limits
Veryl	5	MARYLAND N/A			BALTIM	ORF					1 X Yes 2 No
the h	Director	10e. Street and Number	·		DALITE	10f. Zip Code			10g. Citizen of V	What Countr	γ?
Sa o		924 E PATTERSO	א סאסג אז	7ENIIE		2122	25		U.S.A		
death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. V	+		Specify Yes or No rto Rican, etc.)		e - America	
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heath and Menalle Hygiene. Department of Heath and Menalle Hygiene. Department of Heath and Menalle Hygiene. Examiner must be notified at the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎖 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	ZNo.	1	Yes, specify Cub  ☐ Yes 2 No		rto Rican, etc.)	Specify	ck, White, et	
P P P	8	15. Decedent's		- 1	16a, Deced	ent's Usual Occur	pation		16b. Kind of Bu	usiness/Indu	ustrv
in 72	Completed	(Specify only highest g	rade completed)	( 5·)	(Give I life. D	kind of work done O NOT use retire	pation during most of wo d)	orking			,
iene i	E	Elementary/Secondary (0-12) 8th grade	College (1-4	ior 5+)	LONGS	HOREMAN			STEAM S	HIP T	RADE
of Hyd	BeC	17. Father's Name (First, Middle, Las	st)				18. Mother's Na	ame (First, Middle,			
Aenta de tre et ce	10	JAMES CANNON					VICTO	RIA WILL	IAMS		
s me	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Meilin	Address (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip C	Code)
alth e		John K, Cannon S	r./Son					wood, Md	21040		
of He and a second		20a. Method of Disposition	TD	20b. P	ace of Dispos	ition (Name of atory or other pla	ice)	Date	20c. Location -	City or Tow	n, State
Page Int: If		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ale		ILLE CEN		02-13-0	JARRET	TSVIL	LE, MD.
permit. Departminents Imports eny Inje		21. Signatur of Funeral Service Lice	De De	000	WI		BROWN CO	OMMUNITY	FUNERAL	HOME	P.A.
2/2/E/N/X/D	-	The Part I Enter the disease or co	malications that cau	sed the death			RTH AVENU		rrest	7.5	Approximate
Dh. di		Ma. Fart1. Enter the disease, or co- shock, or heart faiture. List only	y one cause on eac	tine.						1	Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final	Α.	. 1		- \/	. \	17		!	
Examiner		disease or condition resulting in death)	a				isular	Disc	27	1	
张 碳.	ē			Due to (or	as a consequ	ience or):				1	
uted d ansit	Examiner	Conventially list and disease	b	Due to (or	as a consequ	ience of):					
exec in en riel-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		20010 (0)	40 4 0011004	101100 017.					
icele be executed physician end s the buriel-transit	edicai	that initiated events	C	Due to (or	as a consequ	ence of):				-	
tifice of phy es th	2	resulting in death) Last			,	,				1	
The law requires that the death certificate has been signed by the attending page 2 should be deteched for use est	Physician/M		d							1	
deat de att	Sich	Part II. Other significant conditions	contributing to deat	h but not resu	Iting in the un	derlying cause giv	ven in Part I.	23b. Did 1	tobacco use cor	ntribute to t	the cause of death?
res thet the de signed by the a i be deteched i	څ							10	Yes 2□ No	3 Proba	bly 4 Unknown
graded as the	þ										
v require been si									an autopsy med?	avail	e autopsy findings lable prior to
aw re 2 sh	pie										pletion of cause eath?
Physician: The la rthis certificate her	Completed							101	ras 212No	10	Yes 2□ No
rtiffice Stor,	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o	nne)	-	
yalcl is ce direc	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Inp	atient 2 🗆 I	ER/Outpatient	3□ DOA Oth	ner: 4 Nursing	Home 5 ☐ Resid	dence 6/20th	er (Specify)	hospice
ig Pt ter th neral		27. Manner of Deeth 1 ☑ Natural 5 ☑ Pending	28e. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Inju Wo	ry et rk?	28d. Describe I	now injury occurr	ed	
ath. He fu	볉	2 ☐ Accident investigati					Yes 2□No				
r Atte	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place of	Injury - At ho		et, factory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural I	Route Number,
ed in the state of											
To the Hospital or Attending Physician: within 24 hours effer death.  To the Eunerel Director. After this certific completely filled in by the funeral director,	edicai	(Check only 2 Medical Exa	hysician: To the be miner: On the basi	s of exeminati							
the the the land	Z E	one)	and manne	r stated.		29c. Licens	e number		29d. Date signed	d (Month D	av Vaarl
S N N N		29b. Signature and title of certifier				250. Licens			2 A	2 -	.,, roui,
1		Dr. Im			1000	DH	085L1		7/9	1000	
5		30. Name and address of person who	completed cause	of death (Item	23e) (Type, F	rint)		n .			
V82		David Riseb	erg 301	5T C	BUL	1 Dal	4more	2120	2		
Stat Registra		31. Date filed (Month, Day, Year)	Again.	istrar's Signat	4	ocks					
riegisti	"	FEB 1 2 2004	pull per	- for	Polylo	ware					

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H rtificate of L		mentai Hy	giene 2 Reg. No.	2004	04288
			1. Decedent's Name (First, Middle, L.	ast)				2. Date of De			3. Time of Death
	Physici /Medio		Evelyn Leon			February 9, 2004		11:59 PM			
>	Examin		4a. Facility Name (If not institution, gi	ive street and number,	)	4b. City, Town, or	Location of Dear			ounty of Death	
			Renaissance Gard	dens		Catonsvi	lle		Ba	ltimore	
	Funeral			Sex 7. A 1 ☐ M 2 ᡚ F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ıy, Year)	9. Birthp	place (State or Foreign entry)
	Director		214 30 3000	10 M 2X F	99 Yrs.			FEB 6,	1905		land
-	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mantal Hygiens. Introprent: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Miscled Examiner must be nutitied at 90ce.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					Od. Inside City Limits
- Pro-		Funeral Director	Maryland Baltimo	.11e					1 ☐ Yes 2 🗓 No		
9			10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
-	10 6	ā	709 Maiden Choic	ce Lane		21228			USA		
ŧ	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (5	Specify Yes or No		Race - Americ	can Indian.
10.0	liner.	Ë	1 Never Married 2 Married	Armed Forces' 1 ☐ Yes 2√	? No	Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puer	to Rican, etc.)		Black, White,	etc.
38	, ie	۵	3 ☐Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 No	Specify:		Sp	pecify:	White
Ď į	atur	Completed	15. Decedent's E	Education	16a. Dece	dent's Usual Occupa	tion		16b. Kind	of Business/In	dustry
25. 5	. 5 %	pie	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or	5+) Dool	kind of work done d DO NOT use retired Estate CI	oralz	rking	Fodos	rol Cor	ernment
2	gien.	Š	12		Keal	Estate CI	ELK		redei	Lai GOV	eriment
ind 2	al Hy d oth	Be (	17. Father's Name (First, Middle, Las					me (First, Middle			
aryla	Ment	2	Charles Richard Maguire					e August			
Maryland 21215-0036	and and is my		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add						-		
	alth n 27 ner tr		Henry Louis Coll	rollidy 2011		Sextant		Annapol			
ore	of H If ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 I	☐Removal from State	20b. Place of Dispo cemetery, cres	natory or other place	9)	Date		tion - City or To	
timor	ment tant: jury		`4 ☐Donation 5 ☐ Other (Speci	ify)	Mt. Ulive		-			imore,	
Baltimore,	permit. Trages 1 a Department of Hes Important: If item any injury or othe spice.		21. Signature of the McDo	TYNDAM	ulch 2	Name and Address MacNabb F 301 Frede	uneral l rick Ro	Home, P.	A. onsvi]	lle. MD	21228
		ner	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	d the death. Do not ent	er the mode of dying	g, such as cardia	c or respiratory a	rrest,	,	Approximate Interval Between
P	Physician /Medical		Immediate Cause (Final disease or condition	Alasta	c-lambia					700	Onset and Death
			resulting in death)	Due to (or as	a consequence of):	corono	myan	tany a	disac	100	Teas
E	xaminer			b							
			Sequentially list conditions,	b							
2		ne l	cause. Enter Underlying	Due to (or as	a consequence of):						
affic	nd	amine	Sequentially list conditions,  any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of).						
, <b>0</b> ,	ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):						
3760,	hysician and he burial-transit	ical	triat mitiated events	С.	22-1-013945						
		ical	resulting in death) Last	c. Due to (or as	a consequence of):						
	tending physician and or use as the burial-transit	ical	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	c. Due to (or as	a consequence of):	Dectopic pregnancy			23d	. Date of delive	,
	the attending physician and red for use as the burial-transit	ical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. Due to (or as	a consequence of):  of pregnancy 2   Fetal death 3	Ectopic pregnancy			23d	. Date of delive	nry Day Year
	d by the attending physician and letached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5	Other (specify)	n in Part I	22a Did t		Month	Day Year
P.O. Box 68	signed by the attending physician and be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5	Other (specify)	n in Part I.		obacco use	Month contribute to the	Day Year ne cause of death?
P.O. Box 68	een signed by the attending physicien and hould be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5	Other (specify)	n in Part I.			Month contribute to the	Day Year ne cause of death?
P.O. Box 68	as been signed by the attending 2 should be detached for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5	Other (specify)	n in Part I.	1 ☐ `	obacco use Yes 2 N	Month  contribute to the state of the state	Day Year ne cause of death?
P.O. Box 68	as been signed by the attending 2 should be detached for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5	Other (specify)	n in Part I.	1 ☐ `	obacco use	Month  contribute to the state of the state	Day Year  De cause of death?  Ably 4 Unknown  Down findings available inpletion of cause of
P.O. Box 68	as been signed by the attending 2 should be detached for use a	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5	Other (specify)	26. Place of De	1 🗆 1	obacco use of the second secon	Month  contribute to the description of contribute to the description of contribute to the death?	Day Year  De cause of death?  Ably 4 Unknown  Down findings available inpletion of cause of
P.O. Box 68	as been signed by the attending 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No	c. Due to (or as d	a consequence of):  of pregnancy 2 Fetal death 3 time of death 5 cout not resulting in the unit of the country	Other (specify)	26. Place of Dear	24a. Was autor period 1 Yes ath (Check only of lome 5 Resident)	obacco use of section of the section	Contribute to the contribute t	Day Year  ne cause of death? ably 4 Unknown  psy findings available mpletion of cause of 2 No
P.O. Box 68	as been signed by the attending 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death	c. Due to (or as d	a consequence of):  of pregnancy 2   Fetal death   3   1 time of death   5    out not resulting in the unit   2   ER/Outpatient   28b. Time of	t 3 DOA Other	26. Place of Dec	24a. Was autor perfo	obacco use of section of the section	Contribute to the contribute t	Day Year  ne cause of death? ably 4 Unknown  psy findings available mpletion of cause of 2 No
P.O. Box 68	as been signed by the attending 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as d	of pregnancy 2   Fetal death 3   t time of death 5   but not resulting in the unit of the control of the contro	t 3 DOA Other  28c. Injury Work  M 1 Y	26. Place of Dear	24a. Was autop perfo 1 Yes  ath (Check only colorne 5 Residence 1	obacco use of control of the control	Month  contribute to the contr	Day Year  ne cause of death? abiy 4 Unknown psy findings available mpletion of cause of 2 No
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	ifter death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as d	of pregnancy 2   Fetal death   3   t time of death   5   but not resulting in the unit   ent   2   ER/Outpatien	t 3 DOA Other  28c. Injury Work  M 1 Y	26. Place of Dec	24a. Was autop perfo 1 Yes  ath (Check only colorne 5 Residence 1	obacco use of section of the section	Month  contribute to the contr	Day Year  ne cause of death? ably 4 Unknown  psy findings available mpletion of cause of 2 No
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	4 hours after death. Funeral Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural   investigation   i	c. Due to (or as d	ent 2 ER/Outpatien  ary by Year)  28b. Time of Injury 29c. (Specify)	t 3 DOA Other  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Dear at ? es 2 □ No	24a. Was autor performence of the control of the co	obacco use  Yes 2 N  an 2  Siny  Timed?  2 No  one)  dence 6 now injury oc  Street and N  vn, State)	Month  contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contribut	Day Year  ne cause of death? abiy 4 Unknown  psy findings available in pletion of cause of 2 No  // Route Number,  ated.
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	4 hours after death. Funeral Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as d	ent 2 ER/Outpatien  ary by Year)  28b. Time of Injury 29c. (Specify)	t 3 DOA Other  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Dear at ? Yes 2 □ No e, date and place inion, death occurrence.	24a. Was autop performence of the control of the co	obacco use of section of the section	Month  contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contribut	Day Year  ne cause of death? ably 4 Unknown  psy findings available  inpletion of cause of  2 No  I Route Number,  ated. the cause(s)
P.O. Box 68	ifter death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as d	ent 2 ER/Outpatien  ary by Year)  28b. Time of Injury 29c. (Specify)	t 3 DOA Other (specify)  t 3 DOA Other  28c. Injury Work  1 Y  eet, factory, office	26. Place of Dear  4 Aursing F at ? es 2 No e, date and place inion, death occur	24a. Was autop performent of the control of the con	obacco use  Yes 2 N  an  sy rmed? 2 No  one)  dence 6 now injury oc  cause(s) and date and pla  29d. Date si	Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	4 hours after death. Funeral Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as d	ent 2 ER/Outpatien  ent 2 ER/Outpatien  ent 2 Sb. Time of Injury  jury - At home, farm, str.  c. (Specify)  of my knowledge, death of examination and/or invalue.	t 3 DOA Other (specify)  t 3 DOA Other  28c. Injury Work  1 Y  eet, factory, office	26. Place of Dear  4 Aursing F at ? es 2 No e, date and place inion, death occur	24a. Was autop performent of the control of the con	obacco use  Yes 2 N  an  sy rmed? 2 No  one)  dence 6 now injury oc  cause(s) and date and pla  29d. Date si	Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	4 hours after death. Funeral Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as d	of pregnancy 2   Fetal death 3   t time of death 5   but not resulting in the unit of the pout not resulting in the unit of the unit of the pout not resulting in the unit of the un	t 3 DOA Other (specify)  t 3 DOA Other  28c. Injury Work  1 Y  eet, factory, office	26. Place of Dear  4 Aursing F at ? es 2 No e, date and place inion, death occur	24a. Was autop performent of the control of the con	obacco use  Yes 2 N  an  sy rmed? 2 No  one)  dence 6 now injury oc  cause(s) and date and pla  29d. Date si	Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	4 hours after death. Funeral Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as d	of pregnancy 2   Fetal death 3   t time of death 5   but not resulting in the unit of the pout not resulting in the unit of the unit of the pout not resulting in the unit of the un	t 3 DOA Other (specify)  t 3 DOA Other  28c. Injury Work  1 Y  eet, factory, office	26. Place of Dear  4 Aursing F at ? es 2 No e, date and place inion, death occur	24a. Was autop performent of the control of the con	obacco use  Yes 2 N  an  sy rmed? 2 No  one)  dence 6 now injury oc  cause(s) and date and pla  29d. Date si	Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to	Day Year  ne cause of death? ably 4 Unknown  psy findings available  inpletion of cause of  2 No  I Route Number,  ated. the cause(s)
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certified	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as d	ent 2 ER/Outpatien  ary Year) 28b. Time of Injury  of my knowledge, death of examination and/or invaries.	t 3 DOA Other (specify)  t 3 DOA Other  28c. Injury Work  1 Y  eet, factory, office	26. Place of Dear at ? es 2 \( \text{No}\) No e, date and place inion, death occurrumber	24a. Was autop performent of the control of the con	obacco use  Yes 2 N  an  sy rmed? 2 No  one)  dence 6 now injury oc  cause(s) and date and pla  29d. Date si	Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to	Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year CLARK Physician 5:40 ELEANOR 5 2004 FEBRUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hopkins BALTIMOre Johns HOSPITAL The If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Se 7. Age (In yrs. last birthday) Funeral Months Days 1 ☐ M 2 💢 F Yrs. 219-22-0128 Md. Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ntal Hygiene. ed other than "natural", or items 23a or 23a-f show event, the Madical Examiner must be notitled at 1 Yes 2 □ No Funeral Director Md. NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with i nent of Hauth and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23e or i not or other traumatic event, the Medical Examiner must be Apt. 1010 USA 21213 1400 E. Madison Street 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Charles Antell 8th grade Factory & Laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Gaskins James Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1826 N. Chester St., Baltimore, Md. Cynthia Bailey Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of himportant: If ites 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cem. 2-12-04 Lansdowne, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Md. 21202 23a. Part1. Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. March F.H. East 1101 E. North Ave. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 8 hours GASTROINTESTINAL BLEEDING Examiner Due to (or as a consequence of): Physiclan/Medical Examin use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? page 2 should be datached 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? TL Yas 2KNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☒ No Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

or Attending Physician: The law requiras that the death certificate be executed Division of Vital Records, P.O. Box 68760,

this

death.

Baltimore, Maryland 21215-0020

Y

State Registrar (Check only

29b. Signature and title of certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Wassr

RES-000

29c. License number

24

29d. Date signed (Month, Dav. Year) FEBRUARY, 11, 2004

Baltimore mo 21287

Wol FRANCO D'ALESSIO N. 600

and manner stated.

32. Registrar's Signature

M.D.

31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

Physician    Physician   Physi			State of Maryla	Certificate of	Death	Reg. No.	104 04290			
Scampage Country (1) 2004   13 3 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Physician					3. Time of Death			
Secular Marris  Secular Marris			becty Marie Cochran		Fek	oruary 10,2	2004 3:30 a.m.			
TO CO CO TO A PARTITION OF THE PARTITION		Examine								
The Country of the Co										
The State of County of Cou			216-24-2556 1 <sup>1</sup> M 2 <sup>1</sup> XF 74	Months Days	Hours Min. 8. Date (Mo	of Birth nth, Day, Year)	9. Birthplace (State or Foreign Country) Kentucky			
Elementary/Secondary (0-12)   College (1-4or 5+)   Tinspector   Flectronics   Tinspector   Tin		pue &		City, Town or Location			10d. Inside City Limits			
Elementary/Secondary (0-12)   College (1-4or 5+)   Tinspector   Flectronics   Tinspector   Tin		Mary f sh	Maryland Baltimore Fs	SOX			1 ☐ Yes 2√∑No			
Elementary/Secondary (0-12)   College (1-4or 5+)   Tinspector   Flectronics   Tinspector   Tin		r 28e	10e. Street and Number			10g. Citizen of	What Country?			
Elementary/Secondary (0-12)   College (1-4or 5+)   Tinspector   Flectronics   Tinspector   Tin		7 with	1120 "A" Old Eastern Avenue	2122	21	U.S.A.				
Elementary/Secondary (0-12)   College (1-4or 5+)   Tinspector   Flectronics   Tinspector   Tin		99p	11. Marital Status 12. Was Decedent Ever in t	U,S. 13. Was Decedent of I	Hispanic Origin? (Specify Ye					
Elementary/Secondary (0-12)   College (1-4or 5+)   Tinspector   Flectronics   Tinspector   Tin	a.m	ours aftar	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				64.			
198. Informant's Name-Presidentionship (Type, Print)  199. Informant's Name-Presidentionship (Type, Print)  190. Mailing Address (Streat and Amberor Phural Floures Number, City or Town, State, 2# Code)  200. Welchood of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  400 Domains   Submit of Disposition   Submit of Di	30	72 h	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occur (Give kind of work done	pation during most of working	g most of working 16b. Kind of Business/Industry				
198. Informant's Name-Presidentionship (Type, Print)  199. Informant's Name-Presidentionship (Type, Print)  190. Mailing Address (Streat and Amberor Phural Floures Number, City or Town, State, 2# Code)  200. Welchood of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  400 Domains   Submit of Disposition   Submit of Di	3:	Althin hen	Elementary/Secondary (0-12) College (1-4or 5+)		ed)					
198. Informant's Name-Presidentionship (Type, Print)  199. Informant's Name-Presidentionship (Type, Print)  190. Mailing Address (Streat and Amberor Phural Floures Number, City or Town, State, 2# Code)  200. Welchood of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  400 Domains   Submit of Disposition   Submit of Di	7 T	lled v lygie her ti	17 Entharts Nama / First Middle Lest	Inspector	10 Mathoda Nama /Fint					
198. Informant's Name-Presidentionship (Type, Print)  199. Informant's Name-Presidentionship (Type, Print)  190. Mailing Address (Streat and Amberor Phural Floures Number, City or Town, State, 2# Code)  200. Welchood of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  200. Method of Disposition  300 Bural 2   Contention   Date   20c. Location - City or Town, State, 2# Code)  400 Domains   Submit of Disposition   Submit of Di	90 an	d be f	James Penson		, .					
Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions of the cause (a) and manner as stated.  Part III. Other significant conditions can be a consequence of:  Part III. Other significant conditions can be a consequence of:	Z 2	hould Me mark		10h Mailing Address (Stree	1					
Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions of the cause (a) and manner as stated.  Part III. Other significant conditions can be a consequence of:  Part III. Other significant conditions can be a consequence of:	.0, ™a	od 2 s Ith en 17 is 1 trau								
Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions of the cause (a) and manner as stated.  Part III. Other significant conditions can be a consequence of:  Part III. Other significant conditions can be a consequence of:	P ē	F Heart term to				•	-			
Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions of the cause (a) and manner as stated.  Part III. Other significant conditions can be a consequence of:  Part III. Other significant conditions can be a consequence of:	AR mo	Peges ant of nt: if it								
Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions of the cause (a) and manner as stated.  Part III. Other significant conditions can be a consequence of:  Part III. Other significant conditions can be a consequence of:	BRU	mit. F Sertm Sortar		22 Name and Addre	ass of Facility					
Physician (Medical Examiner)  To OUT (STATE DIRECT CONTINUE)  The state of the stat	E 9	FEE 8	756			2/2004 Baltimore, Maryland Tuneral Home, P.A. nue, Essex, Maryland 21221				
DIVIDUAL TO CHECK ONLY STATE OF THE PROPERTY O	9	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. LUNG CANCE	ER			inierval Between Onset and Death			
Company   Comp		± 5.0								
		he et ned fo	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause giv	ven in Part I. 23i	b. Did tobacco use co	ntribute to the cause of death?			
	Z 0.	hat the sed by detacl				1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 🛣 Unknown			
	COCHRA ecords,	aw requires t as been signe 2 should be			248		completion of cause			
	~	ate ha				1 ☐ Yes 21 No	1 ☐ Yes 2 ☐ No			
	EE j	stan: entific actor,	25. Was case referred to medical			: only one)				
	E S	hysic his o	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	JER/Outpatient 3 DOA	4 Nursing Home 5					
		ending P seth. or: After t tha funera	27. Manner of Death  1 X Natural 5 Pending investigation  2 Accident (Month, Day Year)	Injury Wor		scribe how injury occur	red			
	Divis	tal or Att rs after de al Direct led in by t	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Special	iome, farm, street, factory, office fy)	28f. Loc: City	Location (Street and Number or Rural Route Number, City or Town, State)				
	4	he Hospi in 24 hou he Funer pletaly fill	29a. Certifier (Check only one)  **Certifying Physician: To the best of my known one of the pass of examiner and manner stated.**	owledge, death occurred at the tir ation and/or investigation, in my o	me, date and place, and due ppinion, death occurred at the	to the cause(s) and ma time, date and place,	anner as stated. and due to the cause(s)			
		To the Total	Lob: O'gridiano dila titlo di dolitilio			_	, ,			
D43725 2/10/04		V			43 125	21	10/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093		X			TIMONIUM. MI	21093				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar			31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature						

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death v 11,2004 **Physician** February Verna Sue Callahan 3:30a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Eastpoint Nursing Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6 - 6 - 1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 K F 213-36-5452 87 N. Director Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
and: if item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified as MD n/a 1⊠Yes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21231 USA 105 N. Chester Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Read's Drug Store Elementary/Secondary (0-12) College (1-4or 5+) Clerk 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ranze Webb Anita Burleson 19a. Informant's Name/Relationship (Type, Printdaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Callahan 124 S. Bouldin St. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2/12/2004 Baltimore, MD Greenmount \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 263 S. Conkling St., Baltimore, MD 21224 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mentin yRS **Physician** /Medical Due to (or as a consequence of): erebrovascular Disease Examiner 5725 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be stroke 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2√No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier master Theraber no D 45757 11,2004 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mather Mc Nathey 4940 Eastern Are MO Balto 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 1 2 2004

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of M	larylan		irtment <i>tificate</i>			ınd M		jiene	2001	01	129
hysician		I. Decedent's Name (First, Middle, Last CATHERINE	DAVE	ENPO	BT					2. Date of Dea Month		Year 2004	3. Time	of Death
Medical xaminer	. 4 x	la. Facility Name (If not institution, give	street and number	T			BALT	Location of IMORE	2			County of Deat		
neral ector		5. Social Security Number 6. Se 212-26-1329  Usual Residence of Decedent	х ] м 2 Д F	86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 12-23-1	, Year)	9. Birt	hplace (Sta nuntry)	
fledat		10a. State 10b. County  MD N/A			y, Town or Lo									e City Limit
ust be notified		10e. Street and Number 1215 POPLAR GROVE	STREET	1		10f. Zip		1216		1	0g. Citiz	en of What Co USA	untry?	
disal Examinations and letter by Funeral	To la far	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ½ If Yes, Give Year or Dates	i? ] No	i i	Was Deced f Yes, spec			gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: BLA	e, etc.	
r, the Medical E		15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-40)	r 5+)	life. I	lent's Usua kind of wor OO NOT us HOMEM	k done d se retired)	uring most	of workir	ng	16b. Kind of Business/Industry HOME			
To Be (	2	17. Father's Name (First, Middle, Last)  AMBROSE JOHNS		18. Mother's Name (First, Middle, Maiden Surname)  ELLA SINGLETON  ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
nit. Pages 1 and 2 sho artiment of Health and ortent: If item 27 is m injury or other traum		19a. Informant's Name/Relationship (T)	N Removal from Stat			4 N. sition (Nam	CALV	ERT S	ST.,	BALTO.	20c. Loc		Town, State	
any inju		21. Signature of Funeral Service Licens		V	22					ES A. MO			IS F.H	., IN
cian dical		23a. art1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each	line.	PTIC	er the mode	e of dying						Approxir Interval Onset a	nate Between nd Death
he burial-transit	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Due to (or a d.	ENA	L /	4BS	C E	SS						
or use as	) sicial miner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	Ectopic pro					2	3d. Date of del Month	ivery Day	Year
		Part II. Other significant conditions co	ulting in the u	ulting in the underlying cause given in Part I.  TULA						se contribute to				
19 2	ou bie								· · · ·	24a. Was a autops perform	SV	24b. Were au prior to death?	topsy findin completion of	gs available of cause of
al director	200	27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In (Month, D		ER/Outpatien		A Othe	r: 4 🗆 Nur	rsing Hon	(Check only on ne 5 Reside 28d. Describe he	ence 6		cify)	
completely filled in by the funeral	THE CARE	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I		ome, farm, str	М	101	es 2□N		28f. Location (Si City or Town		l Number or Ru	ıral Route N	lumber,
completely filled in by the	a car	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the besiner: On the basis	of examina	owledge, death	occurred a	at the tim	e, date and inion, deat	d place, a	and due to the c ed at the time, d	ause(s) ate and	and manner as place, and due	stated. to the caus	e(s)
comple	1	29b. Signature and title of certifier					License					signed (Monti		,
6		30. Name and address of person who c				Print)	2	591	17 L13	ERTY +	02-	-11-2	.00 4 ENGE	
	- 1	KALU UMA U	SESTSIDE 32. Regis	MEA										

				State of Maryland / Department of Health  1- State Registrer  Certificate of Deat			ene 20 (	14 0429	93
		Physicia	an	Decedent's Name (First, Middle, Last)	1	2. Date of Death Month February	Day 200	3. Time of Dea 4 7:10 PM	
		/Medic Examin	al	Evelyn Dawson  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		rebluary	4c. County of		
		Examin	eı	Harford Memorial Hospital Havre de Gra			Harfo		
		Funeral Director		5. Social Security Number  235-03-6453  6. Sex 1 M 2 S F  7. Age (In yrs. last birthday) Months Days Hours Hours	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, 1 Oct 26,	1919	Birthplace (State or Fo. Country) un	
				Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location				10d. Inside City Li	imits
		Maryla -f shov lied at	tor					1 □ Yes 2x	⊇No
		ith tha	Direc	10e. Street and Number 10f. Zip Code		10	g. Citizen of Wh.		
		eath w	eral	27 E. Belair Avenue 21001  11. Marital Status Unk   12. Was Decedent Ever in U.S. Armed Forces?   13. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Process   13. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Process   13. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Process   13. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Process   13. Was Decedent Ever in U.S.   13.		city Yes or No-	14. Race -	SA American Indian,	
_	36	tiled within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23e or 28e-f show ent, the Medical Examittatioust by multified at	y Fun	Armed Forces?  1 Never Married 2 Married 1 Yes, Sive Year or Dates:  Armed Forces?  If Yes, specify Cuban, Mexical Structure S		Rican, etc.)	Black, Specify:	White, etc. White	
0	21215-0036	'2 hour	ted b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during m	most of workin	unk 1	6b. Kind of Busi	ness/Industry	unk
6	121	within 7 ane. Ihan "r	mple	Elementary/Secondary (0-12)  Unk  College (1-4or 5+)  Unk					
-	Maryland 2	e d fa	To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) unk 18. Mo	Nother's Name	(First, Middle, M.	aiden Sumame)	u	ınk
	lary	2 should and Men Is marke	_	19a. Informant's Name/Relationship (Type, Print)  Harford Memorial Hospital  19b. Mailing Address (Street and Nur.)  501 S. Union Aver.					
7 0		s 1 and 2 of Health item 27 I other tre		20a. Method of Disposition 20b. Place of Disposition (Name of				ty or Town, State	
3/6	Baltimore,	Pages ment of ant: If i		1 □ Burial 2 □ Cremation 3 □ Hemoval from State  1 □ Donation 5 ☒ Other (Specify) in state					1
	Balt	parmit. Pages 1 a Department of He: Important: If item any injury or othe		21. Signature of Formeral Service Licensee Ronal Ld S. Wade, Pirector State Anatomy Baltimore, MD	Board 21201	655 W.	Baltimo:	re Street	
N				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h as cardiac or	r respiratory arre	st,	Approximate Interval Betwee Onset and Deat	en uth
		Pnysician /Medical	3	Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	Dise	ase		-	_
		Examiner		Sequentially list conditions.  b. Arthur successive					
		uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
	760,	ate be exacuted hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
_	6876	ficate b physic s the b	edicai						
Me	O. Box	ne death certificat the attending phy had for use as th	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  9 ☐ Unknown  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date Monti		ır
111	s, P.	es that th ignad by be detac	à	Pate II. Other significant continuous continuous to accuracy to accuracy in the accuracy in th	Part I.			oute to the cause of deat	
تے	Record	To the Hospital or Attending Physician: The law raquir within 24 hours after death. To the Funeral Director: After this certilicate has been s completely filled in by the funeral director, page 2 should	Completed			24a. Was ar autopsy perform 1 Yes 2	/ pri	ere autopsy findings ava or to completion of caus ath? ] Yes 2 [] No	ilable se of
Ö	Vital	cian: ertifica actor, p	BeC	25. Was case referred to medical examiner?		(Check only one			
5	ō	ng Physi fter this c ineral dire	on; To	1 Yes 22 No 1 Impatient 2 Envoutpatient 3 DOA 4L	2	me 5 Reside 28d. Describe ho			
3	Division	or Attendi ifter death. Director: A in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Str City or Town	eet and Number , State)	or Rural Route Number	r,
Ă		Hospital 4 hours Funeral ely filled			ate and place, a	and due to the ca ed at the time, da	use(s) and man	ner as stated.  nd due to the cause(s)	
i		o the lithin 2 o tha	Medical	one) and manner stated.  29c. License numb 29c. License numb	nber	29	d. Date signed	(Month, Day, Year)	
		- ≯ + ō		· a an mo Doo	557	22	0210	2/2004	
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Somo (Min 319 Sputh Union Ave-	nue	Have	e de	Grace	
		St Regist	ate trar	The second secon	,				

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #8 PER G829 3/19/04 JH Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician P M DNE IXOV FEBRUARY EORGE 2004 6. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HAMPSTEAD TREE RROL WE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 MM 2□F 228.30.699 Yrs IRGINIA Director MAY 09,1928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ms 23a or 28e-f shor 1 ☐ Yes 2 X No MARYLAND ARROLL AMPSTEAD Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? STREET 21074 Funeral r than "natural", or items the Medical Examiner on Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No þ Specify: WHITE 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SPECIALTY WIRE Elementary/Secondary (0-12) College (1-4or 5+) ARYLANID ABORER YES. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit timent of Health and Mental H tent: If item 27 is marked ott jury or other traumatic even DIXON LILLIAN ျှ DAUGHTOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8117 BONAIRE MONKS DARBARA 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State RIEMORIAL important: any injury o once. FEB. 11, 2004 TIMONIUM, MARYLAND 4 Donation , 5 Other (Specify) GARDENS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PEAKEFUL ILTERNATIVES EUNEDAY TIMONIUM, MD 12325 YORK ROAD ann. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lasculitis Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2. No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this Funeral Director: After that the filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifies icai within 24 ho To the Fun completely ( 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15552 10 who completed suse of death (Item 23a) (Type, Print) We sturnster und 21157 Sarontz Canter ST M. D. 555 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name, (First, Middle, Last) 2. Dete of Deeth Dev **Physician** - Month Year 4b. City, Town, or Location of Death 4c. County of Death SARNER 2025 /Medical 4a Fecility Name (If not institution, give str Examiner BALTO If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Months Hours 78 28 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show **Funeral Director** 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 518 21205 Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status No NYes, Give Year or Detes: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0020 Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECURIT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PARSON 19b. Mailing Address (Street and Number or Tral Route Number, City or Town, State, Zip Code) 21205 GARNER Ke wood AVE-BALTO. Md any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State remptory 2-10-4 DUNdalk MO 4 ☐ Donation 5 ☐ Other (Specify) US JY. FUNERALHOME 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the discorp, or complications that go sed the death. Do not enter shock, or heart fail by . List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) Encephalopath /Medical Examiner Due to (or as a consequence of): by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the e completely filled in by the funeral director, page 2 should be deteched it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? TL Yes 2 210 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No Medical Certification: To 27. Meryer of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and Jitle of certifies 40854 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Riseberg ST PAUL Ballimore 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar 12 And the

DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. I.

Important: If Item 27 is marked other than "neturel", or Items 23e or 28e-f show and sery injury or other treumatic event, the Medical Examiner must be notified at a part of the properties of	4e. Fecility Name (I.  4e. Fecility Name (I.  5. Social Security N  216 97 =  Usual Residence of  10a. State	13 umber 6.5	ve street and n	GOC umber)	DD5			02	07	04	1800	
uneral rector	S. Social Security N 216 97 = Usual Residence of	13 umber 6.5		umper)			4b. City, Town, or		oth 4- O		, , ,	
rector	5. Social Security N 216 97 = Usual Residence of	umber 6. S		•	بمطا	Hishway		bppm v		y of Death	211	
rector	Usual Residence of		Sex 1 AM 2□ F	7. Age (In yrs. Ia		If Under 1 Year	If Under 24 Hrs	8. Date of E		9. Birthpl	ace (State or Foreio	
Items 23e or 28e-f show ner must be notified at uneral Director	-	, 108	1 <b>23</b> M 2□F	3	8 Yrs.	Months Days	Hours Min		14 65	Mary		
ner must be notified a ner must be notified a uneral Director										10	Od. Inside City Limits	
Items 23e or 28e ner must be noti uneral Direc	MD	Allegany	У		Cresa	ptown					1 □ Yes 27 No	
ner must b	10e. Street end Nun					10f. Zip Code			10g. Citizen of		ry?	
L'a		McMuller				21505				JSA		
Exami by F	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 🔀 Married 4 □ Divorced	Armed F	2∭No ive		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or Note 1		ce - America ack, White, e fy: bla	etc.	
ted lea	/0	15. Decedent's E	ducetion		16a. Dece	dent's Usual Occur	pation	45.	16b. Kind of E	Business/Ind	ustry un	
event, the Medical E Be Completed	Elementary/Secol	ify only highest gra ndary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retire	during most or wo d)	rking			uii	
Col			0			cook		: Name (First, Middle, Maiden Surname)				
Be Be	17. Father's Name (	am Goods.							e Lawson			
10	19a. Informant's Na				19b. Maili	na Address (Street		d Number or Rural Route Number, City or Town, State, Zip Code)				
	Mattie G							ural Route Number, City or Town, State, Zip Code) 1e Baltimore, MD 21224				
ŧ l	20a. Method of Disp		7016	20b. Pla	ace of Dispo	osition (Name of matory or other pla	ce)	Date	- City or Tov	vn, State		
	1 □ Burial 2 □ 4 □ Donation	y) in st										
ej l	21. Signature of Ty	onal Service Licer	wade,	Director	Š	Name and Addre tate Anai	ss of Facility Comy Boar	cd 655 V	V. Balti	more S	treet	
	/10	cull,	100	all_		altimore,						
1	23a. Part1. Enter th shock, or hear	ne disease for com t failure. List only	one cause on	caused the death. each line.	Do not en	er the mode of dyir	ng, such as cardia	c or respiratory	errest,	į	Approximate Interval Between Onset and Death	
ian cal	Immediate Cause (I	Final	011		10	anach	le la D.	ctle	И	1	1 1110	
ner	disease or condition resulting in death)	1	e. Un	Due to for	as a conde	quench of	14/2/				7 000	
ii ii	Immediate Cause (Final disease or condition resulting in death)  e. QNOTPINC eucephalop4tly  Due to (or as a consequence of):  b. Gastrountertinal bleeding									1100		
Examiner	Sequentially list con	nditions,	b	Due to (or	as a consec		. /					
<u>a</u>	Sequentially list cor if any, leading to im ceuse. Enter Under Cause (Disease or i that initiated events	rlying Injury	c	seps1						4 wa		
e as the burial-trensit  Medical Examir	resulting in death) L	ast	1	Due to (or	1					ĺ	11.01	
			d	ym p	nor	n a					406	
etached for us Physician/	Part II. Other signifi	cent conditions c	ontributing to d	leath but not resul	ting in the u	nderlying cause giv	en in Part I.	23b. Die	i tobecco use co	ntribute to	the ceuse of deeth	
be detached f								1	Yes 2□ No	3 🗆 Prob	ably 4 ☐ Unknow	
be d										T		
page 2 should be Completed									s an autopsy formed?	ava	e autopsy findings lable prior to pletion of cause	
Compl											eath?	
	25. Was case refern	ed to medical					OC Place of De		Yes 2□No	10	Yes 2□ No	
o B	examiner? 1 Yes 2 !		Hospital: 1	Inpatient 2 E	R/Outpatier	nt 3□ DOA Oth	26. Plece of De er: 4 ☐ Nursing I		sidence 6 Lot	ner (Specify)	WGI	
neral o	27. Manner of Death	5 Pending			28b. Time of			T	how injury occur			
the fu	2 Accident	investigation	1		,,		Yes 2 □ No					
Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place	e of Injury - At hon ing, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or To	(Street and Numi own, State)	ber or Rurel	Route Number,	
S S	29a. Certifier  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cau								cause(s) and m	anner as sta	ted.	
completely filled in by the	(Check only one)  2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.									and due to	the cause(s)	
omp Me	29b. Signature and t		29c. License number				29d. Date signe					
		110	rue	erd .		2	o 83 i		2 -	7-	04	
	30. Name and addre	ss of person who	completed cau	se of death (Item 2	23a) (Type,	Print)						
0.4	URIEL VELA 31. Date filed (Month			McMULLEN Registrar's Signatu		Y CREASPIX	WN,MD					
State Registrar	Aldiana	.,,	Rom		here	3						

			1 - For State Registrar	State of Maryla	and / Dep		lealth and	Mental Hy		_	04297
	Physici /Medio	cal	Decedent's Name (First, Middle, Lass	A	Hicks		r Location of Deat	2. Date of De Month	Day 9	Yeer OU	3. Time of Death
	Examir Funeral Director	ier	5. Social Security Number 6. Se 214-38-4898	VARYLAND	rs. last birthday Yrs.	BAT	If Under 24 Hrs Hours Min.	8. Date of Bir	th	9. Birthp	lace (State or Foreign stry) ginia
e, maryland z iz i 5-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examination was confident at 200c.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  10e. Street and Number  911 W. Lombard Str  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grate  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last)  James King  19a. Informant's Name/Relationship (7)  Gladys Williams /  20a. Method of Disposition  1 XBurial 2 Cremation 3 County (1)  21. Signature of Funeral Service Lidenty	Ba  Teet  12. Was Decedent Ever in Armed Forces?  1	16a. Dece (Give life)  Machi  19b. Mail  911 W  D. Place of Disp cometery, cre  2 2100		specify:  ation during most of wo toor  18. Mother's Nai Hattie and Number or Re 1 Street, 20/13 ss of FacilityThe	rking  me (First, Middle, Traynh, ural Route Number Baltime Date 8/2004	U.S Specific	of What Country  A.  Race - America Black, White, or State, White, or State, Zip D 2122: on - City or To when, Mones F,	an Indian, etc. ck dustry  Code) 3 wn, State D /H, P.A.
,000	Physician /Medical Examiner  pe parial-transit  pe	Ilcal Examiner	23a. Part 1 Enter the disease or companion, or tigart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hypert	ALMA equence of):  AGE equence of):  LMSTON	ter the mode of dyin			rrest,		Approximate Interval Between Onset and Death
O. Box 68	w requires thet the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3[	□Ectopic pregnancy □ Other (specify)				Date of delive Month	ry Day Year
ecords, P.	The law requires thet the death see has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant conditions co	entributing to death but not	resulting in the u	underlying cause give	en in Part I.		Yes 2□No	3 Proba	e cause of death?
	The larate has	e Completed	25. Was case referred to medical				26. Place of Dea	autor	osy rmed? 2X No	prior to con death? 1 \( \text{Yes} \)	osy findings available inpletion of cause of
0	Physici this cer al direc	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)		☐ ER/Outpatie		er: 4 🗆 Nursing H	lome 5 Resid		Other (Specify	)
DIVISION	Attending Par death ector: After to by the funera	atlon;	27. Manner of Death  11 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	yat k? Yes 2 □No	28d. Describe h	how injury occ	curred	
	To the Hospitel or Attending Physician: inip 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ocify)			28f. Location (S City or Tox	vn, State)		
	To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my liner: On the basis of exam and manner stated.	nowledge, deat ination and/or in	th occurred at the time evestigation, in my of	ne, date and place pinion, death occu	red at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	Vithir To the	M	29b. Signature and title of certifier	21		29c. License				ned (Month, L	
	1		30. Name and address of person who o	off ms	tem 23a) /T	Print)	50027			2/9/	04
	9		/ ADAM	" J. GETTO	FF	72 5	50027 6. Green	e Sn	Balt	imar,	MO
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	loaks				,	

Amend item #11 per infor. G833 7/19/04 AMH MICHAEL HRYNCZYSZYN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 1064State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician FEBRUARY** 2004 1602 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 603 S. ANN STREET BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□F 215-30-6649 0-30-33 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No MA Director 10e. Street and Number 10g. Citizen of What Country? ò 4NN 57. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 PNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WM17 3 ☐ Widowed "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) SUI'S MANUFACTOR Elementary/Secondary (0-12) College (1-4or 5+) marked other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ANNA ဂ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - 00 Catherine Parks Sister 105 CONESTOGA Rd 21220 of Health It Item 27 middle River other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State ò Department o Important: It any injury or once. -04 \* 4 ☐ Donation 5 ☐ Other (Specify) Dundalk Say Vew Cremator 22. Name and Address of Facility 2067 East 950 21. Signature of Funeral Service Licenses Wesley Charis 20.44 31 md. 212 Balta Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Circhosis 0+ liver resulting in death) /Medical Due to (or as a consequence of) Examiner Alcoholism Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atte in the past 12 months?
1 Yes 2 No Dav Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6X Other (Specify) AT SCENE Medical Certification; To 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation M within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME FEBRUARY 8, 2004 min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LING LI mid 31. Date filed (Month, Day, Year) 32. Registrar's Signarure

DHMH 17 Rev 1/2001

State Registrar

2004

FFR

		For State Registrar	State of Maryla		rtificate of			Reg. No.	004	U4Z		
		1. Decedent's Name (First, Middle, Las	t)		<del></del>		2. Date of Dea		Vana	3. Time of Dea		
Physicia			Dorothy	<b>F.</b>	Harringto	on	2	Day 8	Year 2004	2:00p.		
/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of Death			inty of Death			
CXAIIIII	eı	2503 Violet Avenu		ıth	Baltimor				N/A			
Funeral		5 Social Security Number 6 Se	ax 7 Ane (In vrs	s. last birthday,	If Under 1 Year		8. Date of Birt (Month, Da		9. Birtho	olace (State or Fo		
Director		218-18-8897	□м 2∰ 84	Yrs.	Months Days	Hours Min.	(Month, Da)	-1920	Coui	Md		
Mo W		10a. State 10b. County	10c. C	City, Town or L	ocation				1	10d. Inside City Li		
13	ō	Md N/A	Δ	Baltin	nore					XXYes 2		
288	Jec.	10e. Street and Number		24272	10f. Zip Code			10g. Citizen	of What Cour	ntry?		
9 3	Funeral Director	2503 Violet Ave	enue Apt 510	South	21215			11	S A			
2.5	era	11. Marital Status	12. Was Decedent Ever in				pecify Yes or No		Race - Americ	can Indian.		
E FE	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)	E	Black, White,			
0 1	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		1 ☐ Yes 2 🖔 No	Specify:		Spe	ecity: B1	Lack		
E E	b	15. Decedent's Ed		162 Door	edent's Usuat Occu	nation		16h Kind d	f Business/In	dusta		
e a	et	(Specify only highest grad	de completed)	(Give	e kind of work done  DO NOT use retire	during most of work	king	100. Killa u	i Dusiness/in	uustry		
han a	m p	Elementary/Secondary (0-12)	College (1-4or 5+) N/A			70)	Home  ame (First, Middle, Maiden Sumame)  y Elizabeth Barber  Rural Route Number, City or Town, State, Zip Code)  Baltimore, Md 21215  Date 20c. Location - City or Town, State  14-2004 Arbutus, Md					
lygie her t	Be Completed	5th grade	N/A	поц	sewife	40 Mark and Mark	a (Cian Maidalla	14-14 0				
d off		17. Father's Name (First, Middle, Last)							•			
Men	မ	John H. Toyer				Mary	Elizabe	th Bar				
h and Mental Hygiene. 7 Ia markad other than "I traumatic event, Ina Mad		19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ing Address (Street	t and Number or Rui	ral Route Numbe	r, City or To	wn, State, Zip	Code)		
alth 27 I		Erma Holt - Daug	ghter	253	O Boarman	n Avenue	Baltim	ore. M	id 212	215		
oth oth		20a. Method of Disposition		Place of Dispo	osition (Name of					own, State		
ant o ht: # y or							4-2004	Arbuti	us. Md			
permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: if item 27 la marked other than "natural; or iteme 23a or 28a-f ahow any injury or other traumatic event, the Madical Exemples must be nullified at once.  To Be Completed by Funeral Director		1X Burial 2 Cremation 3 Demoval from State cemetery, crematory or other place)										
Depa Impo any ii		25	て~レ\		z. Namo and Addre	oss or ruemty rice i	on r.m.	WEST				
02.00		Brusan	Dreke			4300 Wa	hash Av	enue	Balto,	Md 21		
		23a. Pari 1. Enter the crease, or composhork, or heart farure. List only	dications that caused the dea									
waisian		Shown, of House land of Class of the	one cause on each line.	ath. Do not en	iter the mode of dyi	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between		
ıysician	Î	tmmediate Cause (Final disease or condition	one cause on each line.			ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between		
Medical		tmmediate Cause (Final	a. CON di	equence of):	accest			rest,		Approximate Interval Between		
•		tmmediate Cause (Final disease or condition resulting in death)	a. CON di	equence of):	accest			rest,		Approximate Interval Between		
Medical kaminer	her	tmmediate Cause (Final disease or condition resulting in death)	a. CON di	equence of):	accest	eng, such as cardiac		rest,		Approximate Interval Between		
Medical kaminer	mlner	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Out di  Due to (or as a conse	equence of):	accest			rest,		Approximate Interval Between		
Medical kaminer	Examiner	tmmediate Cause (Final disease or condition resulting in death)	a. Out di  Due to (or as a conse	equence of):	accest			rest,		Approximate Interval Between		
Medical and purial-transit	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consect.	equence of):	accest			rest,		Approximate Interval Between		
Medical and purial-transit	a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consect.	equence of):	accest			rest,		Approximate Interval Between		
Medical and purial-transit	a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d.	equence of):  oquence of):  equence of):	accest					Approximate Interval Betwee Onset and Dea		
Medical and purial-transit	a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregrant to the consecution of the consecuti	equence of):  equence of):  equence of):  equence of):	My F	sectensi		23d.	Date of delive	Approximate Interval Betwee Onset and Dea		
Medical and purial-transit	a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of preging the pregnant at time of	equence of):  equence of):  equence of):  equence of):	d hab	sectensi		23d.	Date of delive	Approximate Interval Betwee Onset and Dea		
Medical and purial-transit	a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregring the pregnant at time of 9 Unknown	equence of):  organic of):  equence of):  equence of):  nancy tal death 3 ( death 5 (	Wy f	vertensi		23d.		Approximate Interval Betwee Onset and Dea		
Medical and purial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregring to the pregnant at time of 9 Unknown ontributing to death but not re	equence of):  organized of the sequence of the	Wy f	vertensi	.00	23d.	Month	Approximate Interval Betwee Onset and Dea		
Medical and purial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregring the pregnant at time of 9 Unknown	equence of):  organized of the sequence of the	Wy f	ven in Part I.	.00	23d.	Month ontribute to the	Approximate Interval Betwee Conset and Dea		
been signed by the attending physician and moderached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions conditions of the conditions	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregration of the pregnant at time of 9 Unknown ontributing to death but not re	equence of):  organized of the sequence of the	Wy f	ven in Part I.	23e. Did to	23d. obacco use ci 'es 2 Knc	Month ontribute to the	Approximate Interval Betwee Onset and Dea		
as been signed by the attending physician and major 2 should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions conditions of the conditions	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregring to the pregnant at time of 9 Unknown ontributing to death but not re	equence of):  organized of the sequence of the	Wy f	ven in Part I.	23e. Did to 1 1 24a. Was autop	23d.  bbacco use co  'es 2 Divo  an 24	ontribute to the 3 Prob	Approximate Interval Betwee Onset and Dea		
as been signed by the attending physician and major 2 should be detached for use as the burial-transit	a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions conditions of the conditions	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregration of the pregnant at time of 9 Unknown ontributing to death but not re	equence of):  organized of the sequence of the	Wy (sector) _ underlying cause girl	ven in Part I.	23e. Did to 1 1 24a. Was autop	23d.  Obacco use of the control of t	ontribute to the autoprior to condeath?	Approximate Interval Betwee Onset and Dea		
as been signed by the attending physician and major 2 should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of the conditions of the cause of the conditions of the cause of the caus	a. Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  23c. If yes, outcome of pregrand.  1   Live birth   2   Feel	equence of):  organized of the sequence of the	Ectopic pregnance Other (specify)	ven in Part I.	23e. Did to 1	23d.  bbacco use co fes 2 No an 24 med? 25 No	ontribute to the autoprior to condeath?	Approximate Interval Betwee Onset and Dea		
certiticate has been signed by the attending physician and mapped on use as the burial-transit control of the c	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of the conditions of the cause of the conditions of the cause of the caus	a. Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)	equence of):  organized of the sequence of the	Ectopic pregnanc Other (specify)	ven in Part I.	23e. Did to 1	23d.  bbacco use co  'es 2 No  an 24  sy med? 2 No  ne)	Month  ontribute to the autoprior to condeath?	Approximate Interval Betwee Onset and Dea		
certiticate has been signed by the attending physician and mapped on use as the burial-transit control of the c	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions or examiner? 1 ☐ Yes 2 ☐ No 27. Wanner of Death	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown ontributing to death but not re 0 Structory Hospital: 1 Inpatient 2	equence of):  On and equence of):  equence o	Ectopic pregnanc Other (specify) underlying cause given any characteristic cause given any characteristic cause given any characteristic cause given any characteristic cause given any characteristic cause given any characteristic cause given and ch	ven in Part I.  26. Place of Deather: 4 \( \text{Nursing Ho} \)	23e. Did to 1 1 Yes 24a. Was autop perfor 1 Yes	23d.  bbacco use co  yes 2 No  an  sy  med? 24  No  ne)	Month  ontribute to the autoprior to condeath?  1 Yes  Other (Specific	Approximate Interval Betwee Onset and Dea		
certiticate has been signed by the attending physician and mapped on use as the burial-transit control of the c	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consect.  Due to (or as a consect.)  Due to (or a	equence of):  on and equence of):  equence o	DEctopic pregnanc Other (specify)  underlying cause gring  A Charl  ont 3 DOA  of 28c. Injury Wo	ven in Part I.  26. Place of Deather: 4 \( \text{Nursing Ho} \)	23e. Did to 1 1 24a. Was autop perfor 1 1 Yes th (Check only o	23d.  bbacco use co  yes 2 No  an  sy  med? 24  No  ne)	Month  ontribute to the autoprior to condeath?  1 Yes  Other (Specific	Approximate Interval Betwee Onset and Dea		
certiticate has been signed by the attending physician and mapped on use as the burial-transit control of the c	To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consect.  Due to (or as a consect.)  Due to (or a	paquence of):  paquen	Ectopic pregnanc Other (specify)  underlying cause given the control of the contr	ven in Part I.  26. Place of Deather: 4 \( \text{Nursing Hotels} \)  17 at the control of the co	23e. Did to 1 1 1 24a. Was autop perfor 1 1 Yes th (Check only or ome 5 1 Residence 28d. Describe h	23d.  bbacco use co  'es 2 No  an 24  rmed? 2 No  lence 6 Co  iow injury occ  Street and Nu	Month ontribute to the autoprior to coideath? 1 Yes Other (Specificurred	Approximate Interval Betwee Onset and Dea		
certiticate has been signed by the attending physician and mapped on use as the burial-transit control of the c	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consect.)  Due to (or as a co	paquence of):  paquen	Ectopic pregnanc Other (specify)  underlying cause given the control of the contr	ven in Part I.  26. Place of Deather: 4 \( \text{Nursing Hotels} \)  17 at the control of the co	23e. Did to 1 1 Yes 24a. Was autop perfor 1 Yes th (Check only o	23d.  bbacco use co  'es 2 No  an 24  rmed? 2 No  lence 6 Co  iow injury occ  Street and Nu	Month ontribute to the autoprior to coideath? 1 Yes Other (Specificurred	Approximate Interval Betwee Onset and Dea		
certiticate has been signed by the attending physician and map ector, page 2 should be detached for use as the burial-transit and	To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a consect.  Due to (or as a consect.)  Due to (or a	paquence of):  paquen	DEctopic pregnanc Other (specify)  underlying cause gri  A CLOT  at 3 DOA  by A 28c. Inju  M 1  treet, factory, office	ven in Part I.  26. Place of Deal ther: 4 \( \text{Nursing Ho} \)  17. Place of Deal ther: 17. Place of Deal ther: 18. Place of Deal ther: 19. Place of Deal ther: 26. Place of Deal ther: 27. Place of Deal ther: 28. Place of Deal ther: 29. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 20. Place of Deal ther: 21. Place of Deal ther: 22. Place of Deal ther: 23. Place of Deal ther: 24. Place of Deal ther: 25. Place of Deal ther: 26. Place of Deal ther: 26. Place of Deal ther: 27. Place of Deal ther: 28. Place of Deal ther: 29. Place of Deal ther: 29. Place of Deal ther: 29. Place of Deal ther: 29. Place of Deal ther: 29. Place of Deal ther: 20. Place o	23e. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23d.  obacco use of the control of t	Month  ontribute to the state of the state o	Approximate Interval Betwee Onset and Deal Onset an		
certiticate has been signed by the attending physician and map ector, page 2 should be detached for use as the burial-transit and	To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. Due to (or as a co	equence of):  On anancy tall death 3 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 6	DEctopic pregnance Other (specify)  underlying cause given the cocurred at the total control of the cocurred at the total control of the cocurred at the total control of the cocurred at the total cocurred cocurred at the total cocurred cocur	ven in Part I.  26. Place of Deal her: 4   Nursing Horry at 17th?  17es 2   No	23e. Did to 1 1 1 24a. Was autop perfor 1 Yes th (Check only of 28d. Describe h 28f. Location (S City or Tow	23d.  bbacco use co fes 2 No an 24 sy med? 2 No ne) lence 6 O low injury occ fireet and Nu m, State)	Month  ontribute to the state of the state o	Approximate Interval Betwee Onset and Deal Park Park Park Park Park Park Park Park		
certiticate has been signed by the attending physician and mapped on use as the burial-transit control of the c	edical Certification; To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of pregi 1   Live birth 2   Fe 4   Pregnant at time of 9   Unknown ontributing to death but not re 0   Structure   Consent   1   Inpatient 2   28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specials of Consent   28c. Place of Injury - At building, et	equence of):  On anancy tall death 3 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 6	Ectopic pregnanc Other (specify)  underlying cause grand  and 3 DOA  to 28c. Injuny  M 1 Catent, factory, office th occurred at the transport of the occurred at the occurred at the transport of the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurre	ven in Part I.  26. Place of Deal ther: 4 □ Nursing Ho try at trik? 1 Yes 2 □ No	23e. Did to 1 1 1 24a. Was autoperform 1 Yes th (Check only of the Check only of the Check only of the City or Town 28d. Describe h 28f. Location (Society or Town and due to the ored at the time, of	23d.  Dibacco use of the second secon	Month  ontribute to the contribute to the contribute to the prior to condeath?  1 Yes  Other (Specificurred	Approximate Interval Betwee Onset and Deal Onset an		
ectriticate has been signed by the attending physician and mippoctor, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown ontributing to death but not re 0 Structory (Month, Day Year)  28a. Place of Injury - Atl building, etc. (Spec	equence of):  On anancy tall death 3 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 6	Ectopic pregnanc Other (specify)  underlying cause given the courred at the transport of the courred at the transport of the courred at the course of the cou	ven in Part I.  26. Place of Deal her: 4 \( \text{Nursing He} \)  Very at the price of the price	23e. Did to 1 1 1 24a. Was autoperform 1 Yes th (Check only of the Check only of the Check only of the City or Town 28d. Describe h 28f. Location (Society or Town and due to the ored at the time, of	23d.  Delacco use of the symbol of the symbo	Month  ontribute to the autoprior to coldeath?  1 Yes  Other (Specificurred	Approximate Interval Betwee Onset and Deal Pay Year Day Year Day Year Day Year Day Indings avampletion of cause 2 No		
is certificate has been signed by the attending physician and map director, page 2 should be detached for use as the buriat-transit	edical Certification; To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown ontributing to death but not re 0 Structory (Month, Day Year)  28a. Place of Injury - Atl building, etc. (Spec	equence of):  On anancy tall death 3 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 6	Ectopic pregnanc Other (specify)  underlying cause given the courred at the transport of the courred at the transport of the courred at the course of the cou	ven in Part I.  26. Place of Deal ther: 4 □ Nursing Ho try at trik? 1 Yes 2 □ No	23e. Did to 1 1 1 24a. Was autoperform 1 Yes th (Check only of the Check only of the Check only of the City or Town 28d. Describe h 28f. Location (Society or Town and due to the ored at the time, of	23d.  Delacco use of the symbol of the symbo	Month  ontribute to the contribute to the contribute to the prior to condeath?  1 Yes  Other (Specificurred	Approximate Interval Betwee Onset and Deal Pay Year Day Year Day Year Day Year Day Indings avampletion of cause 2 No		
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	edical Certification; To Be Completed by Physician/Medical	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. Due to (or as a co	equence of):  On anacy equence of):  paquence of):	Ectopic pregnance Other (specify)  underlying cause grounderlying	ven in Part I.  26. Place of Deal ther: 4   Nursing Ho try at trk?  Yes 2   No time, date and place, opinion, death occur se number  3 8 0 4 6	23e. Did to 1 1 Yes 24a. Was autop perfor 1 Yes th (Check only or come 5 1 Resid 28d. Describe h 28f. Location (S City or Tow and due to the ored at the time, or	23d.  bbacco use of symbol 24 symbol 24 symbol 24 symbol 25 symbol 26 symbol 26 symbol 27 symbol 27 symbol 28 symbol 29 symbol	Month  ontribute to the autoprior to coldeath?  1 Yes  Other (Specificurred	Approximate Interval Betwee Onset and Deal Park Park Park Park Park Park Park Park		
certiticate has been signed by the attending physician and map ector, page 2 should be detached for use as the burial-transit and	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d. Due to (or as a co	equence of):  On anacy equence of):  paquence of):	DEctopic pregnanc Other (specify)  underlying cause grand of 28c. Injuny Wo M 1  treet, factory, office th occurred at the treet, specification, in my office 29c. License	ven in Part I.  26. Place of Deal ther: 4   Nursing Ho try at trk?  Yes 2   No time, date and place, opinion, death occur se number  3 8 0 4 6	23e. Did to 1 1 1 24a. Was autoperform 1 Yes th (Check only of the Check only of the Check only of the City or Town 28d. Describe h 28f. Location (Society or Town and due to the ored at the time, of	23d.  bbacco use of symbol 24 symbol 24 symbol 24 symbol 25 symbol 26 symbol 26 symbol 27 symbol 27 symbol 28 symbol 29 symbol	Month  ontribute to the autoprior to coldeath?  1 Yes  Other (Specificurred	Approximate Interval Between Onset and Deal Onset a		

			Please	Type or Print in Black In State of Maryland / Dep	delible Ink. Ensure All	Copies A	re Legible.				
			For State Registrar	Ce	rtificate of Death	Reg.		+ 04300			
	Physici /Medio		1. Decedent's Name (First, Middle, Las	GINS	]		Day Year 10,2004	3. Time of Death 9:15 P M			
	Examir	er	4a. Facility Name (If not institution, give 19601 GRAYSTON		4b. City, Town, or Location ol Death WHITE HALL		4c. County of Deat BALTIMO				
	Funeral Director		5. Social Security Number 6. Security Number 1	7. Age (In yrs. last birthday) □ M 2☑ F  56  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 05/18/1	9. Birt Co	hplace (State or Foreign funtry) SISSIPPI			
	show		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			3 1 7 11 1 10 1	10d. Inside City Limits			
	the Mar 28e-f st	ector	MD BALTIM	ORE WHIT	E HALL  10f. Zip Code	100	. Citizen of What Co	1 □Yes 2 No			
	ath with 23a or ust be	ral Dir	19601 GRAYSTON	E ROAD	21161	109.	USA	unuyr			
920	be filed within 72 hours atter death with the Maryland lat Hyglene. d other than "netural", or Items 23e or 28e-f show event, tre Medical Exertirer must be rediffed at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 TYYes 2 TNo	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 🎛 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WF	e, etc.			
21215-0036	within 72 ho ene. than "netur he Medical I	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation 16a. Dece de completed) (Give life.	dent's Usual Occupation kind of work done during most of workin DO NOT use retired) JTER SYSTEMS MAI	S'		Industry MARYLAND INSURANCE			
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, tre Hi	To Be Co	17. Father's Name (First, Middle, Last) EVERETT EVON		18. Mother's Name	(First, Middle, Mai	iden Sumame)				
	# 2 # g	•	EVERETT EVON LANGLEY  GEORGIE SMITH  19a. Informant's Name/Relationship (Type, Print)  SHANNON STUART  DAUGHTER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip.  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip.  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip.  19c. Location - City or Town  20b. Place of Disposition (Name of Date 20c. Location - City or Town)								
Baltimore,	00		1 ☐ Burial 2 XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State CARROLL	CREMATION 02/12	2/2004 I	HAMPSTEA	AD, MD.			
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	JACO 2	2. Name and Address of FacilityHENI 16924 YORK RD	RY W. JI • MONKTO	ENKINS 8 ON, MD 2	SONS CO.			
	Physician /Medical		23a. Part1. Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	blications that caused the death. Do not enone cause on each line.  LUNG CANCER  a.  Due to (or as a consequence of):	er the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death UNKNOWN			
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as a consequence of):							
60,	eath certificate be executed attending physician and for use as the burial-transit	al Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):		<del></del>					
9289	rtificate ng physi s as the l	Medica	IF FEMALE:	d							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physiclan/Medica	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year			
	en signed b	ď	Part II. Other significent conditions or	ontributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to	the cause of death?			
Il Records,	sician: The law requ certilicate has been rector, page 2 should	Completed				24a. Was an autopsy performed	death?	topsy findings available completion of cause of			
f Vital	S 50	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death	1	e 6 ⊡Other (Spec	eifv)			
ion of	ing After une		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how i					
Division	F 5 F C	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st. building, etc. (Specify)	eet, factory, office 2	8l. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,			
	o the Hospital of ithin 24 hours all to the Funeral Dompletely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medicel Exem	ysicien: To the best of my knowledge, deat ilner: On the basis of examination and/or in and manner state).	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
	5 5 E	Σ	29b. Signature and title of certifier	//	29c. License number	29d.	Date signed (Month	Day Year)			

To the Hos within 24 h To the Fur 10

> State Registrar

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

KARITHAMON ISAAC, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD., 21902

31. Date filed (Magnin Day Year) 2004

Registrar's Signature

29c. License number

D40723

29d. Date signed (Month, Day, Year) FEBRUARY 11,2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 9:10 PM 5 2004 IYON /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Min. M 2□F NONE February 5,2004 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if itsm 27 is marked other then "nature!" or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at ouices. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Randallstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? COURT 21133 10 usaFuneral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: BLACK Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWP 19a. Informant's Name/Relationship (Type, Print) ( BMC 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) TOWSON MD 21204 NIPEL CHILCOAT PATHOLOGY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State GREEN MOUN 12004 BALTIMORE, MD \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HONRY W. JENFINS + SINS CO. 22. Name and Address of Facility AMONACO MONKLON, MD 16424 YORK RD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** borroamoro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed cete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy
1 ive birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes > No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funstal Director: After this filled in by the funeral 27 Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50546 pleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004 2 FFB1

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** CN Rachel H. Knight /Medical 4c. County of Deeth 4h City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner a thmore Sinai CIT Baltimore N/A HOSPITA 01 If Under 1 Year | if Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) JAN 8, 1910 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours **Funeral** Months 1 ☐ M 2 🗓 F Maine 94 Director 004-34-4189 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28e-f ahow other traumatic event, the Medical Exandrer must be multised at 1 XYes 2 No Baltimore Director N/A Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 USA Rogers Avenue 2211 W. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Maryland 21215-0036 by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) County permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "r any injury or other traumatic event, the Med page. College (1-4or 5+) Elementary/Secondary (0-12) Government Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carolyn Brown Brydon Harding ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lutherville, MD 21093 Virginia K. Gartland/Daughter 8619 Chelsea Bridge Way Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2-10-04 Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Lyneral Service L. Edward A. Cremation Society of MD, Inc. nach Gregorchik MD 21228 299 Frederick Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prewnown NAV **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 signed by the attending physician d be detached for use as the buris IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, should be 1 Yes 2 No 3 Probably 4 Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy page 2 s has 1 Yes 2 No certificate of Vital 26. Place of Death (Check on one ector. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑No 1 Inpatient 2 ER/Outpatient 3 DOA 2 þ this 28d. Describe how injury occurred funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: After Division 1 Natural 5 Pending 1 Yes 2 No M after death. 2 Accident investigation completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Res -000 W ITall 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 do Registrar

Rachel

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** 10, FEB 10:00am William Baldwin Kemp /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Carroll Carroll View Care Home Manchester Hours Min. APR 4, 1919 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year Months Deys 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) **Funeral** Months 1₩ 2□ F Yrs. 216-16-3330 Director Usuel Residence of Decedent 10d. Inside City Limits death with the Marylend 10c. City. Town or Location 10a. State 10b. County if fem 27 is marked other than "natural", or items 23a or 28e-f show or other traumstic event, the Madical Examinal must be notified at 1 Tyes 2 No Carroll Manchester Director Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2510 Bachman Valley Road 21102 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours aftar 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Laborer th end Mental Hygier 7 is marked other th permit. Peges 1 and 2 should be file.
Deperment of Haeith end Mental Horizortant: if item 27 is meriany injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNK. UNK. Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2510 Bachman Valley Road Manchester, MD 21102 Barbara Burnham/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2/11/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Li 22. Name and Address of Facility
Cremation Society of Maryland, Inc. Dawn F. Baltimore, MD 21228 299 Frederick Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner De to/or es a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law raquires thet the death certificate be executed within 24 hours elate death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completaly filliad in by the funeral director, pege 2 should be deteched for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 1 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) ASSU tel 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 1 Natural 5 ☐ Pending investigation Attending 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted.

| Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 6 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) m Rocho 31 A North wood 31. Date filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar

			1 - For State Registrar	tate of Maryland / D	epartment of F Certificate of		ntal Hygiene	4004 U43114
i	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)     One of the control	Kearne	ahh 4b. City, Town, o	F	Date of Death Month Da -eDruger	3. Time of Death S: 50 M
	Funeral Director		4a. Facility Name (If not institution, give street are boulevand baltimare) 5. Social Security Number 6. Sex 11XM	7. Age (III yrs. last birti	nday) If Under 1 Year Months Days	altimore   If Under 24 Hrs.   8   Hours   Min.   8	Date of Birth (Month, Day, Year, 12–30–23	NA
	e Maryland 8e-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Md. NA	10c. City, Town	or Location imore			10d. Inside City Limits 1 1 Yes 2 □ No
	s 23s or 20 nust be re	Funeral Director	10e. Street and Number 1623 N. Caroline St			.213		itizen of What Country? USA
980	72 hours after death with the Maryland natural', or items 23s or 28e-f show dical Examiner must be notified at	by	1 Never Married 2 Married	Vas Decedent Ever in U.S. Armed Forces?  √☐ Yes 2 ☐ No Î Yes, Give /ear or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (Specit an, Mexican, Puerto Ric Specity:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or items 23s or 28s-f show avent, the Medical Examiner must be notified at	Completed	15. Decedent's Educatio (Specify only highest grade core Elementary/Secondary (0·12)  12th grade  1	npleted) College (1-4or 5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retired ever Worked	during most of working d) -		(ind of Business/Industry
Maryland		To Be	17. Father's Name (First, Middle, Last) William  19a. Informant's Name/Relationship (Type, F	Kearney	Mailing Address /Street	18. Mother's Name (F Helen		n Sumame) Williams or Town, State, Zip Code)
altimore, Ma	1 and 2 Health a lem 27 is		Robert Coty Gua  20a. Method of Disposition  1. Decrea 2 Cremation 3 Remo	rdian 20b. Place of I	7400 Rooseve Disposition (Name of corematory or other place	elt Blvd.,	Philda.,	
Baltin	permit. Pages Department of Important: If II any Injury or o	(	21. Signature of Funeral Service Licenses	Walter	22. Name and Addre	ss of Facility	Baltimor 1101 E.	outus, Md. Te, Md. 21202 North Ave.
	Physician /Medical		23a. Pa. Efter the disease, or complication hock, in heart failure. List only one call minediate fause (Final disease or condition resulting in death)	ons that caused the death. Do not use an each line.  Crive n  Due to (or as a consequence of	ricular	11	to mes	Approximate Interval Between Onset and Death S Week
8/60,	ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of				
O. Box 6	death certific e attending p id for use as	Physician/Medic	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of delivery Month Day Year
cords, P	The law requires that the the has been signed by thoage 2 should be detached.	ed by	hronic Obstr	ting to death but not resulting in uctive u	Monary	Disease		use contribute to the cause of death?  No 3 Probably 4 Unknown
итан жес		e Complet	Paranoid Sc 25. Was case referred to medical	hizophra	enia	26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
ō	T = 0	n; To B	examiner? 1 ☐ Yes 2 No Hospi  27. Manner of Death 28	a. Date of Injury 28b. Tir		er: 4 Nursing Home	5 Residence  Describe how injure	
UIVISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation	Be. Place of Injury - At home, farr building, etc. (Specify)	M 10	Yes 2 □ No	Location (Street an City or Town, State	nd Number or Rural Route Number, a)
	the Hospital or hin 24 hours afte the Funeral Dir nptetely filled in	Medical C	(Orack only 2   Madical Examinat:	n: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the tim for investigation, in my of	ne, date and place, and pinion, death occurred :	I due to the cause(s) at the time, date and	and manner as stated. d place, and due to the cause(s)
	Within To the Comp	Ž	29b. Signature and title of certifier  Lunched c	RNA	29c. License	19334	~1	te signed (Month, Day, Year)  Nuary 10, 2004
	Ch	10	30. Name and address of peson who complete on M. Palacpac  31. Date filed (Month, Day, Year)	ause death (Item 23a) (T 3900 32_Registrar's Signature		iven Bou	levard,	Baltimore, MD alai8
	Sta Registr		- San Harris ( San Jan )	Trogistial a digitatule	1		-	

			1 - For State Registrar	State of I	Marylan	d / Depa	artmen rtificat	t of H e <i>of L</i>	lealth a	and M	lental Hy	giene	200	† Non	04305
	Physici /Medic	al	1. Decedent's Name (First, Middle  All Con Kre  4a. Facility Name (If not institution	bs	ar)		4h City	Town or	Location (	of Death	2. Date of De Month Feb.	Day	Yea	24	3. Time of Death
	Examir Funeral Director	ier	University of Maryla 5. Social Security Number 217-24-8215	nd Medical C	enter	last birthday) Yrs.	Bal	tim			8. Date of Bir (Month, Da May 25		9.1		ce (State or Foreign y) Land
	e Maryland Ba-f ahow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carrol	1	10c. Cit	y, Town or Lo	cation	er							d. Inside City Limits 1 ☐ Yes Ž∭No
	be filed within 72 hours after death with the Maryland tial Hygiene. And other than "natural", or items 23a or 28a-f ahow event, the Medical Esantral must be notified at	Funeral Director	10e. Street and Number 1542 Old West 11. Marital Status	minster Pi	nt Ever in U.	.S. 13.	10f. Zip	211	- 1	igin? (Spi	ecify Yes or No Rican, etc.)	U.	S.A.  14. Race - A	mericar	n Indian,
-0036	2 hours after atural', or ite	by	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Nes 2 ( If Yes, Give Year or Date	□No	16a. Dece	1 ☐ Yes	2∐ No	Specify:				Specify:	/hit	:e
2121	e filed within 72 at Hygiene. I other than "ne vent, the Media	Completed	(Specify only highes Elementary/Secondary (0-12)  17. Father's Name (First, Middle, 1	t grade completed) College (1-4c	or 5+)	(Give	kind of wor DO NOT us Sett	rk done d se retired	during mos ()		ing  (First, Middle	Bla	ck & I		
Ž.	2 should be f and Mental I is marked of sumatic eve	To Be	Charles Allen 19a. Informant's Name/Relations	Krebs			-		Pear	St.	iffler al Route Numb	er, City o	r Town, State	a, Zip C	Code)
Baltimore, M	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		Jerry F. Krebs  20a. Method of Disposition  1  Burial 2 Cremation  4  Donation 5 Other (St	3 □Removal from Sta	l c	lace of Dispo	sition (Nan	ne of ther plac	e)		eboro, Date 2004	20c. Lc	cation - City		
Baltii	permit. B Departm Importa any inju		21. Signature of Funeral Service I	icensee LLL		FC	Name an khard 96 Ch	d Addres t Fu armi	ss of Facility ineral 1 Dr.	I Cha Mar	apel P.	A. r, M	d. 211	02	
1760,	/Medical burial-transit the burial-transit	dicai Examiner	23a. Part. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or c.	ine.	ence of):			g, such as	Cardiac	r respiratory a	rrest,		fr	Approximate interval Batween on the care interval Batween on the care in the c
. Box	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetel	death 3	Ectopic pro					2	23d. Date of Month	,	ay Year
Records, P	w requires that the been signed by th should be detache	by	Par II. Other significant condition					_	en in Part I.		TII.	obacco u Yes 2[			cause of death?
Rec	The faw ate has b page 2 s	e Completed	deep vein thro	mbosis					OS Plane	of Dooth	24a. Was autor perfo	osy rmed? 2 \( \text{No}\)	prior t death	o comp	y findings available pletion of cause of
	ng Phys fter this neral dii	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investig  3 Suicide 6 Could in	ation of he	njury Day Year)	ER/Outpatien 28b. Time of Injury	M 2	Bc. Injury Work	er: 4 □ Nu	rsing Ho	me 5 Residence 1	dence (	y occurred		
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4  Homicide determi	ned 288. Place of building,	etc. (Specify	v) wledge, death	occurred :	at the tim	ne, date an	d place.	28f. Location (: City or Tou	vn, State,	and manner	as state	ed
	rothe H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	xaminer: On the basis and manner	stated.	tion and/or in	29c	. License	number		ed at the time,	29d. Dat	e signed (Ma	nth, Da	ny, Year)
	γ Sta	to.	30. Name and address of from Angela Lee 31. Date Nied (Month, Day, Year)	who completed cause of	f death (Item ,2 So strar's Signa	23a) (Type	Print)				imore			-52500	
	Registr		FEB 122	004	in Sign	Ans	SL.								

			For Stete Registrar	State of Ma	aryland / Do	epartr C <i>ertifi</i>	nent of H	lealth and N Death		jiene 2	2001	+ 0430
	Physici	0.00	1. Decedent's Name (First, Middle, I	Last)					2. Date of Dea Month		Yeer	3. Time of Death
,	/Medic		Forrest Kelley						Februa	ry 8,	2004	7:45 AM M
į	Examin	er	4a. Facility Name (If not institution, g Westminster N		۵		lestmin:	Location of Death			nty of Death	1
	Funeral			. Sex 7. Ag	e (In yrs. last birth	day) If	Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rroll 9. Bjrth	nplace (State or Foreign
	Director		218-26-1730	1፟፟፟M 2□F	73 Y	rs. Mo	onths Days	Hours Min.	8. Date of Birth (Month, Day Jan 23,	1931	Mar	yland
	pug *		Usual Residence of Decedent  10a. State 10b. County	18.30	10c. City, Town	or Locatio	n					10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f ahow rmust be notified at	ŏ		roll		tmin						1 ☐ Yes 2√∑ No
	r 28a-	Director	10e. Street and Number			11	Of. Zip Code		1	l0g. Citizen	of What Cou	untry?
	th with	ai D	32. E. George	Street			2115	7		ī	JSA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was	Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	lace - Amer Black, White	ican Indian, . etc.
9	tiled within 72 hours after Hygiene. Ither than "natural", or Ita ant, the Medical Examina	by F.	1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give				Specify:			cify: wh	
	thour		15. Decedent's				S Usual Occupa			16b. Kind of		
<u>0</u>	hin 72 3. 3. "na Media	plet	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5		Give kind ife. DO N	of work done of IOT use retired	luring most of work )	ing			,
Ž	e filed within al Hygiene. I other than " vant, the Me	Completed	6	0		high	way ad	ministrat			e of	Md
	a d ta b a se	Be	17. Father's Name (First, Middle, La James Jeremiah k	*				18. Mother's Nam			·	
Ž	d 2 should be th and Mental ?7 is marked of traumatic av	은	19a. Informant's Name/Relationship		10h N	Asilina Ac	Idross (Street	Gertru and Number or Run				Thompson
2	- E N =		Peggy Kelley/s			•		Street 1				157
ē,	1 ar Hea Bm tha		20a. Method of Disposition	<del></del>	20b. Place of E	isposition	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			20c. Locatio		
altillo	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Control C	city)	Jointoly,	Cromator	y or ourer place					
סמונ	permit. Pages Department of I Important: If its any injury or o		21. Junatura 1 Funeral Societ Lion 1 Id S	Wade ir	otor	Stat	me and Address e Anato imore,	omy Board	655 W.	Balti	more	Street
		-	23a. Patr1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	emplications that caused by one cause on each li	the death. Do no					est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of	):					-	10 gre
	Examiner		Conventially list appditions	COPI	>							25yr
۰	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of	):						,
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of							15 yr
Š,	be exician burial	aiE		デザイ	Disadiance							25412
/00	ificate g phys as the	edicai		d								23_/5-
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death		pic pregnancy er (specify)				Date of deliv Month	very Day Year
ords, r	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	s contributing to death b	ut not resulting in t	he underl	ying cause give	on in Part I.	23e. Did tol			the cause of death?
ב ני	The law reate has bee page 2 sho	Completed					· .		24a. Was a autops perform	n 24l	b. Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of
<u> </u>	cian: sertific actor,	Be (	25. Was case referred to medical examiner?	Literation			011	26. Place of Deatl	(Check only on	e)		
5	Phyai this c	-T	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:		4.0	DOA Othe	4 wantursing no	me 5 🗆 Reside 28d. Describe ho			fy)
	ding h. h. After funer	tion	1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	Year) 250. Til		28c. Injury Work	ai ? Yes 2 □ No	280. Describe no	ow injury occ	urrea	
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he compietely filled in by the tuneral director, page	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be One Diese of Init	ury - At home, farm c. (Specify)	ı, street, f			28f. Location (St City or Town	reet and Nur n, State)	m <i>ber or Rur</i>	al Route Number,
	a Hospita 24 hours a Funaral letely filled	edical C	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination and/	death occ or investig	urred at the tim pation, in my op	e, date and place, inion, death occurr	and due to the cared at the time, d	ause(s) and ate and place	manner as s e, and due t	stated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	,			29c. License	number	2	9d. Date sign	ned Month.	Day, Year)
1			John W. 7	millet	m		D2	5443		2/9	1/200	04
			30. Name and address of person who	no completed cause of d	ton 68	8 F	Poole	Road	Wesi	Amins.	kr.M	דפועסו
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 2 2	32 Registra	ar's Signature	bank	2	,			•	,
			I Ben La La Pol La	- 12	- 0							

State of Maryland / Department of Health and Mental Hygiene

0	1	0	0	40.7
- 1 1	1 2	1	0	- 1
0	mul's	U	V	- 1

]	MAN	Τ,	For State Registrar	Otato of the	, idila	Cer	tificate	e of L	Death			Reg. No	2004	0430	1
		H	1. Decedent's Name (First, Middle, Lasi	)							2. Date of De		W.c. SYear	3. Time of Death	
	Physicia /Medic		JAMES LAVO	N LEWIS							Februa	ary	06, 2004	2210 P M	A
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location	of Death		40	. County of Deeth		
			Bon Secours Hosy					Ltimo					N/A		
	Funeral		Social Security Number     6. Se	X 7. Age	(In yrs. last b		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Year</i>	9. Birthp	place (State or Foreign htry)	ın
	Director		21/-15-49//	3M 2U F	16	Yrs.					APRIL	12 ]	L987 MAR	YLAND	_
	pu *		Usual Residence of Decedent  10a, State 10b, County		10c. City, To	wnorlo	cation						1	Od. Inside City Limits	
	aryla sho	č												1 DXYes 2 □ No	
	he M	Directo	MARYLAND N/A  10e. Street and Number		В	ALTI	MORE 10f. Zip	Code				10a C	itizen of What Cour	atry?	
	with t	Ö							7					,	
	ss 23	erai	1005 N MONROE S	12. Was Decedent B	ver in U.S.	13 \		2121		igin? (Spe	city Yes or N		J.S.A.	can Indian,	
	iter d	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ 4	lo						city Yes or N Rican, etc.)		Black, White,		
8	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2XXXVo	Specify:				Specify: BLA	.CK	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than *natural', or Items 23e or 28e-f show than *natural', or Items 27e or 28e-f show the Medical Exertines Les routtled at	Completed	15. Decedent's Edi (Specify only highest grad		16	a. Deced	dent's Usua	I Occupa	ition	t of worki	na.	16b. F	Kind of Business/In	dustry	
2	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	kind of wor DO NOT us	e retired,	)		.9				
2	filed wi Hygien other th	Col	11th grade			STU	DENT						N/A		_
2	tal H d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maidei	n Sumame)		
<u>ya</u>	should be ind Mental marked o	မ	JAMES L LEWIS SR								BASS				
ā	2 sh and is m		19a. Informant's Name/Relationship (T)		1								or Town, State, Zip		
ຜົ	1 and 1 10 alth 10 mm 27 her tr		Bernadette Banks/( 20a. Method of Disposition	Grandmothe	20b. Place				e_St		altimor		Maryland ocation - City or To		-
0	Pages nent of H int: If Ite		1XXBurial 2 ☐ Cremation 3 ☐ I		cemet	ery, cren	natory or of	ther place	9)			200. 2	out on the	July Store	
altimore,	t. Pa rtmer rtant sjury		*4 □ Donation 5 □ Other (Specify		MT Z		CEMTE			02-14	1-04	LAI	NSDOWNE,	MARYLAND	_
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If I lem 27 is marked other than "natural", or I tems 23a or 28a-f show any injury or other traumatic event, tra Medical Examinat rules by modified at Quee.		21, Signature of Funeral Service Licens	1 Jane	10	WI		I C E	BROWN	COM		FUNI	ERAL HOME	P.A.	
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do		206_W er the mode					arrest.		Approximate	
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	Θ.		hot				,	,		Interval Between Onset and Death	
15	Physician /Medical		disease or condition resulting in death)	a. Due to (or as		-	1001	200		2					_
	Examiner			Due to (or as	a Comsequen	oi).									
j.		ē	Sequentially list conditions, if any, leading to immediate cause that liberty is Cause (Disease or injury	b. Due to (or as	a consequence	e of):									_
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c											
o Î	an an rial-tr	Ex	resulting in death) Last	Due to (or as	a consequence	e of):									
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d								<del></del>			_
_			IF FEMALE:		,										-
Box	ath ce ttend or us	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal dea		Ectopic pr						23d. Date of delive Month	ery Day Year	
P.O.	e de the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 _	Other (sp	ecify)							
	<ul> <li>requires that the death ce been signed by the attendi should be detached for use</li> </ul>	Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the u	nderlyina c	ause cive	en in Part I		23a. Did	tobacco	use contribute to the	he cause of death?	
Records,	signe d be	1 by	, and a second	, <b></b>			,	3			1 🗆	Yes 2	No 3□Prot	pably 4 ⊟Unknowr	n
Ö	requ	Completed			-						24a. Wa	2 20	24h Ware auto	psy findings available	٩
ě	has has	mpi									auto		prior to co	mptetion of cause of	•
a	n: The		05 W								1DXYes	2 🗆 N	o 100 Yes	2□ No	_
Division of Vital	Physician: The l this certificate ha ral director, page	o Be	25. Was case referred to medical examiner?	Hospital:	nt 2 🖽 🕏 PVC	)t==t.==	• • • • • • • • • • • • • • • • • • • •	Othe	25.		(Check only		6 DOther (Consul	L.)	_
ō	Physical distribution	-	1 XYes 2 No 27. Manner of Death	28a. Date of Injur	y 28b	. Time of		8c. Injury Work	4 🗀 140	-	28d. Describe		6 □Other (Specifing occurred)	y)	
on	ding h. Afte fune	tion	1 ☐ Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	1.75	Injury	> м		(? Yes 2∭X	No	Sw	bjer	t was s	hot	
<u>IS</u>	or Attending Physician: The law requires that the death ce tter death. Director: Atter this certificate has been signed by the attendi in by the funeral director, page 2 should be detached for use	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At home,		eet, factory			1	28f. Location	(Street a	nd Number or Rura		_
á	al or s after if Dire	Certification:	4 Homicide determined	building, etc	Stres	et					AVR.			K Moshor	,
	ospita hours unera ly fille			sicien: To the best								cause(s	s) and manner as s		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	one)	iner: On the basis of and manner sta		and/or in				atti occuiii	erni) eri) is de				_
	To t To t	Σ	29b. Signature and title of certifier	40 >			290	. License	number			29d. Da	ate signed (Month,	Day, Year)	
	\		I hy hi.	m.				0.C.	M.E.			Febr	cuary 07,	2004	
	1		30. Name and address of person who of	completed cause of d	eath (ttem 23a					D-11		14	erland 21	201	
	- 0		31. Date filed (Month, Day, Year)		ar's Signature	111	renn	str	eet,	Rati	.шюrе,	mai	ryland 21	201	
	Sta Registi			2 Hogisti	4	1	rocks	-30							
DH	HMH 17 Rev 1/2		FEB 1 2 2004	1 Marie	~	page	- coup								_

ORIGINAL

		1. Decedent's Name (First, Middle, Last)			2. Dete of Dee	Dev Year
	Physician /Medical	ELIZABETH	L. LANE		Februar	m 9 2004 11:30A.
	Examiner	4a Fecility Neme (If not institution, give street	1 0	4b.	City, Town, or Location of Death	Δ Δ
		NORTH ARUNDEL	HOSTITAL	G	JUNDER 24 Hrs. B. Date of Birt	HNNE ARUNDEL
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birth		Hours Min. (Month, Da)	y, Year) Country)
	Director	214-225185 Usual Residence of Decedent	A //		July 12	2 1926 Maryland
	p	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Many 4	Md. Anne Aruno	del Co. Pas	adena		1 □ Yes 2 □ No
	128a	10e. Street end Number		10f. Zip Code		10g. Citizen of Whet Country?
	ifter death with the Mar r flems 23s or 23s-f si iner must be notified Finneral Director	801 221 ST		211:	22	U.S.A.
	deat	11. Marital Stetus 12. 1	Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban.	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
0	eftar or ft	1 ☐ Never Married 2 ☐ Married	Yes 2 No		Specify:	Specify: white
21215-0020	within 72 hours eftar death with the Marylend ene. than "natural" or items 23s or 23s-f show he Medical Exeminer must be notified at homoleted hy Furners i Director	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			
7	ed within 72 horygiene.  For then "naturality fre Medical Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	Decedent's Usual Occupetion  (Give kind of work done dur life. DO NOT use retired)	on ing most of working	16b. Kind of Business/Industry
2	withir	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesperson		G.C. Murphy
CA	Po Set	17. Fether's Neme (First, Middle, Last)	0		8. Mother's Neme (First, Middle,	
an	Mental H Mental H Introduction	Charles	Tracey		Edna	Burr
Maryland	should nd Men marke umarke	19a. Informant's Name/Relationship (Type,		Mailing Address (Street and		er, City or Town, State, Zip Code)
	alth a	Charles F. Lane	(Husband)	801 221 ST.	Pasadena, Md.	21122
ē,	f Height of the officer	20a. Method of Disposition	cemeter	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or Town, State
Ë	Pege ant c nt: if iry or	1 Burial 2 ☐ Cremation 3 ☐ Remo		aven Memoria	l Pk. 02/13/04	Glen Burnie, Md.
Baltimore,	parmit. Per Depertman Important: any injury once.	21. Signature of Funeral Service Licensee		22. Name and Address	of Facility -Polyniak Funer	cal Homo p A
œ	parm Depe Impo any i	1 1 7 6	1/20	3204 Mot	intain Road, pa	sadena, Md. 21122
		23a. Part Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complex of the compl	ons that caused the death. Do n	ot enter the mode of dying,	such as cardiac or respiratory ar	rrest, Approximate Interval Between
and the	Physician	Silver, or heart failure. Electricity one	1	1	N	Onset and Death
1	/Medical	Immediate Cause (Final disease or condition	multiple of	year H	irkne	20 hours
71	Examiner	resulting in death)	Doe to (or es a o	onsequence of):	- 1 ) -	
	axecuted in and ial-transit	b. <u>/</u>	Schemic	sower o	and liver	•
	and and II-tran	Sequentially list conditions, if eny, leading to immediate	Due to (or es e o	onsequence of):	_	
90	be a: ician buria	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	aruseus.	mellile	N	
Box 68760,	auth certificate be axecuted attending physician and for usa as the burial-transit	resulting in death) Last	Due to (or es a c	onsequence ory:	-1	1 rese
X	ath certification ittending for usa as	<b>L</b> d <i>D</i>	mme oor	/munic p	muna a	n sist
_			uting to death but not resulting in	the underlying cause given	in Part I. 23b. Did t	tobacco use contribute to the cause of death?
P.O.	The lew requiras thet tha da ate has been signed by the a page 2 should be datached				1)20	Yes 2□ No 3□ Probably 4□ Unknow
	s the					•
Ď	The lew requiras the sate has been signed page 2 should be designed.				24a. Was perfo	an autopsy ormed?  24b. Were autopsy findings available prior to
ပ္မ	ew re as be 2 sh					completion of cause of death?
Ĕ	sician: The lew certificate has birector, page 2 s				101	Ycs 2X No 1 ☐ Yes 2X No
İta	entification.	25. Was case referred to medical			26. Place of Death (Check only o	one)
Ž	Physician: rthis certific and director,	1 ☐ Yes 2 No	Inpatient 2 ER/Out		4 Nursing Home 5 Hesi	
E C	After the funere	27. Manner of Death 1 Naturel 5 Pending		ime of 28c. Injury e njury Work? M 1 ☐ Ye	es 2 🗆 No	how injury occurred
Sio	Attending or death.  octor: After by the fune	2 Accident investigetion 3 Suicide 6 Could not be	8e. Plece of Injury - At home, fal			Street and Number or Rural Route Number,
Division of Vital Records,	tal or Attending P rs after death. al Director: After t led in by the funera	4 ☐ Homicide determined	building, etc. (Specify)	in, died, laddy, diled	City or Tox	wn, State)
_	Hospital 24 hours Funeral staly filled	29a. Certifier	n: To the best of my knowledge	, death occurred at the time,	, date end place, and due to the	ceuse(s) and manner es stated.
	thin 24 hours thin 24 hours the Funer impletaly fil	(Check only 2 Medical Examiner: one)	On the basis of examinetion end end manner steted.	d/or investigation, in my opin	nion, death occurred at the time,	date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completaly filled in by the funeral director, page	29b. Signature and title of certifier		29c. License r	number	29d. Date signed (Month, Day, Year)
		ACA	MS	D43	777	esman 9 20010
5	6 4	30. Name end a wress of person who comp	eted cause of deeth (Item 23e) (	Type, Print)		
_	V	Chyolen Organia.	30 Homotor DX	Eure, Colon E	Jume my	21061.
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	M. Bossi		
	Registra	FEB.	LIN CABUT JUNEAU			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2004

3. Time of Death

ORIGINAL

	State of Maryland / Department of Health and Mental Hygiene  1- For State Mental Hygiene Dr., G828,02/12/04dhbCertificate of Death  Reg. No. 2004	04310
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  V. JACQUEUNE LEM KEUDE  2. Date of Death Month Day Year Jan DG ZOOY  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death 4c. County of Death	3. Time of Death 1537 M
Funeral Director	The Johns Hokins Hospital  5. Social Security Number  1. Security Number  207-26-1503  1 M 2 F 71  1 Yrs.  Baltimore C; ty  If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)  (Month, Dey, Yeer)  March 24, 1932  9. Birthple Count March 24, 1932  March 24, 1932	ace (Stete or Foreign 7) land
ith the Marylan or 28s1 show re notified at		d. Inside City Limits 1 □ Yes 2 No
er death w	820 Butter Road  17315  U.S.A.  11. Marital Status    Image: Never Married   N	tc.
Maryland 21215-0036 at 2 should be filed within 72 hours ett filth and Marial Hygiens 27 le marked other than "naturel; or retraumatic event, the Medical Exam.  To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMARY  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	ustry
Marylan and 2 should be all h and Mental all h and Mental all traumatic every fraumatic every	Robert Price  Mary Fay Shields  19a. Informant's Name/Relationship (Type, Print)  Carl Lemkelde/Husband  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.  820 Butter Rd., Dover, PA 17315	Code)
aftimore, mit. Pages 1 at partment of Heap portament of Heap portament if them y injury or otheres.	20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Supering Crematory or other place)  4 Donation 5 Other (Specify)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place)  20c. Location - City or Town State Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or other place Supering Crematory or o	17315
Physician /Medical Examiner	24 Second St., New Freedom, PA 17  23a. Pert 1. Enter the disease, or complications that daised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only die cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Approximate niterval Between naset and Death
Vision of Vital Records, P.O. Box 68760, vision of Vital Records, P.O. Box 68760, vision of Vital Records, P.O. Box 68760, actor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit liftcatton: To Be Completed by Physiclan/Medical Examiner	d	703
P.O. Box 68 that the death certifics of by the attending plateshed for use as the physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ay Year
# 3 / P all Records, P all Records, P all Records that cate has been signed to page 2 should be det.	23e. Did tobacco use contribute to the	
of Vital Record Physician: The law requir r this certificate has been si	25. Was case referred to medical examiner?  Hospital:  Check only one)	
Division of V Division of V tal or Attending Physics after death.  sa for death.  sa for death is coled in by the funeral direction.  Certification: To	1 Empatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
Div Div Ital or Ital or Ital Div Ital Div Ital Div		
To the Hosp within 24 hou To the Fune completely fill	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Da	ne cause(s)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State Registrar	MICHAECHAN CODON WATEST, BALTMORE MD 3 31. Date filed (Month, Day, Year)  See 1 2 2004  See 2004	21212

		•	For State Registrar	State of Marylar	nd / Depa		ealth and l	Mental Hyg		4 04311
	Physic /Med Exami	ical	Decedent's Name (First, Middle, L     BESSIE MA     Aa. Facility Name (If not institution, gu	E MUMFORD		4b. City, Jeym, or	Location of Death	2. Date of Dea Month	Day Yea 05 200 4c. County of De	4 6.10 P.M.
	Funeral Director		5. Social Security Number 6.  214-40-0045  Usual Residence of Decedent	2 705 / 1 0 1	last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da)	DUC	irthplace (State or Foreign Country) OUTH CAROLINA
	death with the Maryland ms 23a or 28a-f ahow	Director	10a. State 10b. County  MARYLAND BALT  10e. Street and Number	IMORE CO	ESSE				10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 🖾 No  Country?
<i>b.</i>	ē # #	Funeral	717 HYDE PARK  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		2122 Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc.
lum for	within 72 hours after ene "natural", or ite than "natural", or ite	Be Completed by	3登Widowed 4□Divorced  15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12∨rs	Year or Dates:	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busine	
2 7	Marylaliu Z.I.Z. nd 2 should be filed within Ith and Mental Hygiene. 27 is marked other than rtraumatic avant, Lto M.	To Be Co	17. Father's Name (First, Middle, La: EDDIE MATTISON  19a. Informant's Name/Relationship	st)			18. Mother's Na	E DAWKIN	Maiden Surname)	
	altimore, Ind. mit. Peges 1 and 2 s partment of Health ar portant: If item 27 is		Rhonda Terry/Da  20a. Method of Disposition  **Surial 2 Cremation 3  4 Donation 5 Other (Spe	☐Removal from State	Place of Dispo cemetery, crer	lyde Park sition (Name of natory or other plac IEMORIAL	(8)	ltimore, Date -	Maryland 20c. Location - City BALTIMORE	
	permit. Peges Department of important: If is	ğ	21. Signature of Funeral Service Lic	H Powell	W1 3	Name and Addre LLIAM C 321 S PHI	ss of Facility BROWN CO LADELPHI	MMUNITY A BLVD,	FUNERAL HO	OME-HARFORD, P. MD 21001 Approximate
	Physiciar / Medica Examine parties of partie	al Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	rquence of):  Tation equence of):		monic	Cance		Interval Between Onset and Death
	P.O. BOX 68/0 hat the death certificate by d by the attending physic detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
	cords, P.O. Box requires that the death been signed by the atternoord be detached for	δ	Part II. Other significant condition					1 🗆	Yes 2 No 3	e to the cause of death?  Probably 4 Unknown
	f Vital Recovations: The law is certificate has built director, page 2 st	e Completed	25. Was case referred to medical	nal atric		brilla		24a. Was auto perfo	prior prior death 2 No 1 1	
	ng Ph fter th	ation: To B	examiner? 1  Yes 2 No  27. Magner of Death 1 Natural 5 Pending 2  Accident investiga	28a. Date of Injury (Month, Day Year)		of 28c. Inju	ner: 4 🗆 Nursing	Home 5 Resi	dence 6 □Other (5 how injury occurred	
i	Divisio  To the Hospitel or Attendifultion 124 hours after death.  To the Funerel Director: A completely filled in by the fu	sal Certifica	3 Suicide 6 Could no determin  29a. Certifier 1 Certifying		nowledge, dea	th occurred at the t	me, date and place	City or To	wn, State) cause(s) and manne	r as stated.
<b>(</b>	To to cor	Medical	(Check only 2 Medical E. 29b. Signature and title of certifier	and manner stated.	nation and/or if	29c. Licen	se number	)	29d. Date signed (M 2/5/0	
		State	30. Name and address of person w Dr. Jeanette 31. Date filed (Month, Day, Year)	ho completed cause of death (It	em 23a) (Type K	Print) 000 Frau	nKlinSc	juare D	r. Baltır	nore, Md. 2123

DHMH 17 Rev 1/2001

ORIGINAL

				State of Mary	-	artment of F <i>rtificate of</i>			iene <sub>eg. No.</sub> 20	04	04312
		_	1. Decedent's Name (First, Middle, Last)					2. Dete of Deet Month	h	Year	3. Time of Death
	Physiciar /Medica		ORA M	AE M	cDow	ELL		FEBRUAR	Ly 10th 2	004	7.55 PM
	Examine		le Fecility Neme (If not institution, give si	reet and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
	.00 c		FREDERICK VILL		ING CE	1	CATONS If Under 24 Hrs.		Balti	MOR	
	Funeral	5	5. Social Security Number 6. Sex	M 2TF	n yrs. lest birthday) Yrs.	Months Days	Hours Min.	(Month, Day,		9. Birthplac	e (State or Foreign
	Director	-	242-56-8777 1U Usuel Residence of Decedent	94				09-30-1	1909		NC
yland	show a	_	10a. Stete 10b. County		c. City, Town or L					10d	Inside City Limits
Mar	iffed		MD BALTIMORI	E	CATO	NSVILLE					1 X Yes 2 □ No
if t	or 22	Funeral Director	10e. Street end Number			10f. Zip Code		11	0g. Citizen of W	het Country	?
ath w	23	<u>a</u>	1006 KENT AVENUE	0 Wes Day dead Eve		212		poits Vac or No-	USA 14 Bace	American	Indian
Tar de	Rem	֓֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	11. Marital Status 1 Never Married 2 Married 1	2. Was Decedent Ever Armed Forces?	r in U,S. 13.	If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White, etc	
020 Irs af			3 ₹ Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		1□Yes 2∏ No	Specify:		Specify:	BLA	.CK
:1215-0020 within 72 hours aftar death with the Maryland	le al	o be completed by	15. Decedent's Educ (Specify only highest grede	ation	16a. Dece	dent's Usual Occup	petion during most of work	rina	16b. Kind of Bu	siness/Indus	itry
21 ithin	e Paris	DI L	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)				
12 J	it, in the	3	8 17. Father's Neme (First, Middle, Lest)		DOI	MESTIC	18. Mother's Nam	e /First Middle M	HOME		
anc be fi	Mental Harked otl	Q.	ANDER MCLEAN				DICEY	,		0,	
Ly Should	th end Mental Hyg	- 1	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mail	ing Address (Street	and Number or Rur			State, Zip Co	ode)
Maryland 21215-0020	サトゥ	- 1	JOYCE E. MC DOWELL,		100	6 KENT AV	ENUE, CAT	ONSVILLE	E, ME 21	1228	
ຄຸ 🛓	of Heal I frem 2 r other	7	20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or Town	ı, State
mo Pege	- F		1√3Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	REST HAY		1	:/15/04	DUNN,	NC	
	9 9 - 9		21. Signature of Funeral Service License	. 1 2	2						F.H., INC
<b>©</b> 8	on y and		* Lames	1. Whole	in	1701 LAU	RENS STRE	ET, BALT	ro., MD	21217	
			23a. Perti Enter the diseese, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	i In	pproximate terval Between
	ysician									0	Inset and Death
	Medical	- 1	Immediate Cause (Final disease or condition resulting in death)	ATHERO	SCLERO	OTIC CI	ARDIOVA	SCULAR	DISFEA.	SE	YEARS
		.		Due	e to (or as a conse	quence of):				i	
De ja	ansit	edicai Examiner	Convention. List conditions b.	Due	e to (or as a conse	quence of):					
58760, licete be executed	ician and buriel-transit	ב ב	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.			111111111111111111111111111111111111111				i	
68760, ificete be ex	physici	20	Ceuse (Disease or injury that initiated events resulting in death) Last	Due	e to (or as e conse	quence of):			-		
I Records, P.O. Box (The law requires that the death certif	igned by the attanding be detached for use e	Jan	- 3.								
O. F	ched	) Sic	Part II. Other significent conditions cont	ributing to death but n	ot resulting in the	underlying cause gi	ven in Part I.				he cause of death?
, P.O	deta	2						1 1 4	es 2□ No	3 Probal	siy 4 Olikilowii
rds	n sign	D						24a. Was a	n autopsy	24b. Were	autopsy findings
00 %	2 should							perior			eletion of cause
<b>A</b> = 5	ate has	E						1UY	09 2 XNO	101	Yes 2□ No
E E	certificate	9	25. Was case referred to medical examiner?				26. Place of Dear	th (Check only on	ne)	L	
> 1	this ce	0	1 □ Yes 2 No	ospital:		nt 3LI DOA	-	ome 5 Reside			
	h. After ti funara	<u>.</u>	27. Menner of Death 1 → Natural 5 □ Pending	28a. Date of Injury (Month, Dey Ye	ear) 28b. Time of Injury	Wo	ryet irk? ]Yes 2 □ No	28d. Describe ho	ow injury occurr	ea	
Vision of Vita	death	Cat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, st			28f. Location (St	treet and Numb	er or Rural F	Route Number,
Division of Vital Records,	after death Director: /		4 ☐ Homicide determined	building, etc. (5	Specify)	noon rabiory, omo-		City or Town	n, State)		
Spital	neral / filled	<u>8</u>	29a. Certifier 1X Certifying Physi	cian: To the best of m	y knowledge, dea	th occurred at the ti	me, date and place,	and due to the co	euse(s) end ma	nner as stet	ed.
ě Š	within 24 hours after death.  To the Funeral Director: After thi completely filled in by tha funaral	Medical Certification: 10 be Completed by Physicianum	(Check only 2 Medical Examin	er: On the basis of exa and manner stated							
Toth	To the comp	Σ	29b. Signature and little of certifier	44		29c. Licen:	se number	2	9d. Date signed	(Month, Da	ıy, Year)
	5		My Vasan	lhalou	mala	10 D4	2510	/	-EB.	1	2004
	\( \lambda \)		29b. Signature and wite of certifier  CASAN  30. Name and address of person who cor	npleted cause of death	h (Item 23a) (Type	, Print)	COAN #	108 N	10 2/	228	
	SER PIX		IVI-VASANTUAK	UMAL, S	Signature	N CCING	1-21-1, 11				

DHMH 16 Rev 6/95

Registrar

Bruce McLendon 04-01105 MAN

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For	State of Maryland / Department of Health and Mental Hyg	jiene	ZUU4	-0
State Registrar	Certificate of Death	Reg. No.		

			1 - State Registrar	Ce	rtificate of Death	Reg.	No.	07011
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Bruce Mc Len	don		February	09, 2004	2117 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death		4c. County of Death	
*			St. Agnes Hospital		Baltmore			
4	Funeral Director		5. Social Security Number  3.16-54-6299  Usual Residence of Decedent	7. Age (In yrs. last birthday, 5 4 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthp Coun	lace (State or Foreign try) Md
	land		10a. State 10b. County	10c. City, Town or Le	ocation		1	Od. Inside City Limits
	he Mary 28a-f ah	ector	md	Ba/ti	more Co.	100	Citizen of What Coun	1   Yes 2   No
	ath with t	Funeral Director	3815ArbutusAy		21207		U.S.A.	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Itam 27 Is marked othar than "natural", or Items 23s or 28s-f show othar traumatic avent, the Muccel Expedient cast be notified at	þ	1 Never Married 2 Married 1 74es,	s 2 Mo	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B/G	etc.
5-0	72 hc	etec	15. Decedent's Education (Specify only highest grade complete	16a. Dece (Give	ident's Usual Occupation is kind of work done during most of work DO NOT use retired)	king 16b	. Kind of Business/Inc	lustry
2121	filed within Hygiene.	Completed	Elementary/Secondary (0-12) College	e (1-4or 5+)	sembler	n	1anufac	tory
Maryland	ould be filed Mental Hygir arked othar latic avent, II	To Be (	17. Father's Name (First, Middle, Last) RISDEN MChen	don	Kath	le (First, Middle, Maid	Taylor	l
ary	and N	Γ.	19a. Informant's Nam elationship (Type, Print)	19b. Maili	ing Address (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, Zip	Code)
	and 2 saith a n 27 I		Priscilla Brown	Sister 38			to Co. 2120	
ore	0 0 = =		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from		osition (Name of matory or other place)	Date 200	. Location - City or To	wn, State
Ë	Pages ment of thant: If its		* 4 □Donation 5 □ Other (Specify)	mtc	armel 2-	-17-07 P	un dall	k md.
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		2007 Eastern Av	2	MD. 212	3 (
	<b>A 3</b>		23a. Parm. Effer the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arre		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Henosclen	tre (and wiece	wa d	Stere	Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consequence of):		347		
Ę	Lammer	L	Sequentially list conditions, b.	to (or so a consequence of):				
	ed sit	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):				
	certificate be executed uding physician and use as the burial-transit	xan	that initiated events c.	to (or as a consequence of):				
68760,	be e sician buris							
687	ficate g phy: s the	Medical	0.					
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
Д.	that the	Ph	Part Other significant conditions contributing t	o death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
Records,	uires sign	d by	Vianeter rel	litra		1 🗆 Yes	2 □No 3 □ Proba	abiy 4 🗆 Unknown
COL	w requir been si should	Completed				24a. Was an	24b. Were autor	osy findings available
Re	The lav	m C				autopsy performed	? prior to con	npletion of cause of
Vital			25. Was case referred to medical		26 Place of Dea	th (Check only one)	No Yes	2 No
5	Physician: this certific ral director,	o Be	examiner? Hospital:	☐ Inpatient 2 🖾 ER/Outpatie	Other		6 □Other (Specify	·)
101		-	27. Manner of Death 28a. Da	tte of Injury 28b. Time of Injury Injury		28d. Describe how in		,
ion	를 근충 글	atio	2 Accident investigation	injury	M 1 ☐ Yes 2 ☐ No			
Division	al or Attendation after death	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, st ulding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Exeminer: On th		th occurred at the time, date and place, westigation, in my opinion, death occur			
	To the within 2. To the complet	Me	29b. Signature and little of certifier	<del></del>	29c. License number	29d.	Date signed (Month, L	Day, Year)
	- 5 - 0		1 Mr Oska)	)	O.C.M.E.	F€	bruary 10	, 2004
. •	1		3. Name and address of person who completed of	ause of death (Item 23a) (Type,	Print)			
_	`		J. LAKEN WIL	E MO 11	1 Penn Street, Bal	timore, M	aryland 21	201

State Registrar

31. Date filed (Month, Day, Year) FEB 1 2 2004

n al er	1. Decedent's Name (First, Middle, Last	")						1	2. Date of De.	ath			2 Time	400
al	710.12227								Month	Day	. ,	Year	3. Tittle C	of Death
er .					1		Ville		Feburcir	1		064	11:22	Ai
	4a. Facility Name (If not institution, give	/ // /	1/2 /	-1	4b. City,	Town, or	Location of	of Death	40	4c.	County o	Death		
	5. Social Security Number 6. Se	PKINS K	ge (In yrs. la:	et hirthday)	If Under	1 Year	If Under	24 Hrs	8/ Date of Birt	Ph.	NA	O Bish-li	/Ch- 4-	
		NIM 2DE	38	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Count	ace (State ry)	or Forei
ŀ	Usual Residence of Decedent		50						1-20-	00		MG.		
	10a. State 10b. County		10c. City,	Town or Lo	ocation							10	d. Inside C	ity Lim
ģ	Md. NA			Balti	more								YO Yes	2 🗆 1
ire	10e. Street and Number				10f. Zip					-	zen of Wh	at Count	ry?	-
a	800 N. Broadway					2120	5			US	4			
ne	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. ?	. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	- 1				
۲ ۲	1 Never Married 27 Married	1 ☐ Yes 2 ☑ If Yes, Give	No					,	, , , , ,					
ם ס		Year or Dates:	:											
ete	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	dent's Usua kind of wor	l Occupa k done d	ition <i>uri</i> n <i>g m</i> osi	of worki	ng	16b. Kir	nd of Busi	ness/Indi	ustry	
ğ.	Elementary/Secondary (0-12)	College (1-4or	5+)	_		e retired)				,	Varie	25		
		· · · · · · · · · · · · · · · · · · ·			icing		18 Mothe	r's Name	(First Middle					
ă			Millor	_					(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Wild Golf				
۲			ытттег		ng Address	(Street a			I Route Numbe	r City or			Code)	
	Gbemisola Miller- Wit	e -		2403	Picker	ring	Drive,	Apt C	, rioute rumbe	or, only or	03.0	a 10, Zip (	2006)	
ŀ	20a. Method of Disposition	HOCHEL	20b. Plac	ce of Dispo	sition (Nam	ne of								
			,		-		. !					•		
			Gre						0.000			-15 -11	11170	_
	1. At												202	
-	23a, Part 1, Enter the disease, or compl	licatio that cause	od the death								L'UII		Annrovima	la.
		ne se on each l	line.			yg	, 000, 00	<b>34</b> , 3,40 0	. roopiratory at	1031,			nterval Bel	ween
	disease or condition resulting in death)											e.	apt 1	100
		Due to (or as	s a conseque	nce of):	V 2	1100	1							10
_ a	if any leading to immediate		s a conseque	nce of):	sal k	2161	<u>ca</u>					10	ne c	X C
<u>2</u>	Cause (Disease or injury	120th	1.4	0	1	101	0:	ccol	200			10	NE C	V)-V
xa	resulting in death) Last		a conseque	nce of):	KIV	1		1101	1212			11.3	11.10.1	
		4												
ed														
2	IF FEMALE: 23b. Was decedent pregnant									2:	3d. Date o	of delivery	,	
Cla	in the past 12 months?	4□Pregnant a										,		Year
ار ال	9 Unknown	9 Unknown												
	Part II. Dther significant conditions cor	ntributing to death b	but not resulti	ng in the ur	nderlying ca	use givei	n in Part I.		23e. Did to	bacco us	e contrib	ute to the	cause of c	leath'
	Acquired inn	Faborin	icien	1CY	54	nd	rom	-2	1 🗆 Y	es 2	No 3	☐ Probat	oly 4 🖯	Jnkno
ere	\			(					24a Was a	an l	24h Wa	re autons	y findings	avada
E .									autops	sy	Dric	ir to comi	pletion of c	ause
	25. Was case referred to medical										1 🗆	Yes 2	₽Ño	
ă	examiner?	lospital:	a C 55	20.4		Other	12000			-				
- 6		28a. Date of Inju	ury 28			A	4 LI Nur					(Specify)		
		(Month, Da	ay Year)	Injury	м			io		, ,				
100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home	e, farm, stre	et, factory,	office		2	8f. Location (Si	treet and	Number	or Rural F	Route Num	ber.
e L	4   Homicide	building, et	tc. (Specify)						City or Town	n, State)				
	29a. Certifier 1 Certifying Phys	sician: To the best	of my knowle	edge, death	occurred a	it the time	, date and	place, a	nd due to the c	ause(s) a	ind mann	er as stat	ed.	
Salc	(Check only 2 ☐ Medicel Examinate)	ner: On the basis o	of examination	n and/or inv	estigation, i	in my opi	nion, deati	n occurre	d at the time, d	ate and p	olace, and	due to th	ne cause(s	)
	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (A	Aonth, Da	ıy, Year)	
		2	MO		Ω	n 6 -	ODE			EN		, , ,-	7	J
	30. Name and address of person who co	empleted cause of o		3a) (Tyne F		167	000		Rall	TRO	CLY CH	45	1500	136
	Susan Chena		The	ていたへ	c Him	-\/ 0	c 1)	spita	OCUIT	MAJO	ELANG	11/10	CI C	161
POLICE L'ENTITICATION I DIMENSION DIVIDINATION PROPERTIES EXEMINES	medical ceruilcanoli, to be completed by ruysicially medical Examin	3   Widowed 4   Divorced  15. Decedent's Edit (Specify only highest grade)  Elementary/Secondary (0-12)   12th grade  17. Father's Name (First, Middle, Last)  Theodore  19a, Informant's Name/Relationship (Tobamt.sola Miller-Wilsadie Miller)  20a. Method of Disposition  1   Burial 2   Ocremation 3   First American Burial 2   Other (Specify)  21. Signature of uneral Service Licess  23a. Part I. Enter the disease, or compositiock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Dther significant conditions conditions conditions of the past of the p	Sequentially list conditions, if any, leading to death   Acquired   Sequentially list conditions   Sequentially list on the past 12 months?   Sequentially list on the past 12 months?   Sequentially list of conditions   Sequentially list of conditions   Sequentially list of conditions   Sequentially list of conditions   Sequentially list onditions   Sequentially	Sequentially list conditions, if any leading in death) Last   Cause (Disease or injury that imitated events resulting in death) Last   Cause (Disease or injury that imitated events resulting in death) Last   Cause (Disease or injury that imitated events resulting in death)   Cartifler   Cart	15. Decedent's Education   16a. Dece   16b.   16a. Dece   16b.	3   Widowed 4   Divorced   Press of Dates:   1   Yes of Dates:	3   Widowed 4   Divorced   Year or Dates:   1   Yea	S   Widowad   Divorced   Was Give   Specify   Specify or highest grade completed   Specify or highest grade completed   Specify or highest grade completed   Specify or highest grade completed   Specify or highest grade completed   Specify or highest grade completed   Printing   Specify or highest grade completed   Printing   Specify or highest grade completed   Printing   Specify   Specify   Printing   Specify   Specify   Printing   Specify   Specific   Specify   Specify   Specify   Specific   Specify   Specific   Spec	South   Sout	Tyes Green   Tye	Teach   Teac	Specify   Spec	Secondary   Seco	Specify   Spec

				State of Maryla		Department of F Certificate of		_	giene 2 () Reg. No.	104 04315
	D		1. Decedent's Name (First, Middle, Li	ist)				2. Dete of De Month		3. Time of Death
_	. Physici /Medio		Mary	Mills				FEBRUI	HY 8,2	004 1:00AM
)	Examir		4a Fecility Name (If not institution, git	-			4b. City, Town, or Lo		4c. County	
			Stella Maris Mer	<del>-</del>		KII	Baltimo			NA
П	Funeral Director	9		Sex 7. Age (In y		hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		Birthplace (Stete or Foreign Country)
			Usual Residence of Decedent					7-28-	26	Md.
	how #		10a. State 10b. County	10c.	City, Town	or Location				10d. Inside City Limits
	e Ma	ç	Md. NA		Ba.	ltimore				Maria Yes 2 □ No
	it the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	
	ath v	ā	11 W. 20th Stree	<del></del>			1218		USA	
	ar de	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U,S.	13. Was Decedent of H If Yes, specify Cuba	fispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - American Indian, k, White, etc.
2	be filed within 72 hours efter death with the Maryland tel Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Medical Examinat must be notified at	À	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	Black
0200-91212	2 hou	Completed by	15. Decedent's E	ducation	16e.	Decedent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry
Z	thin 7	pie	(Specify only highest gr Elementary/Secondary (0-12)	Ollege (1-4or 5+)		(Give kind of work done of life. DO NOT use retired	during most of worki d)	ng		
	e filed wi el Hygien other th	50	12th grade		1	Domestic	· · · · · · · · · · · · · · · · · · ·			Peoples Home
Maryland	be fill d oth	Be	17. Father's Neme (First, Middle, Last				18. Mother's Name		_	•
ž	should be and Mantel I a marked of	၉	Denver		right		Fannie		Jone	
Σ			19a. informant's Name/Relationship ( Bonne McSwain	Daughter	i	Mailing Address (Street ll Canvassba				
ē,	Health Health em 27 i		20a. Method of Disposition			Disposition (Name of cremetory or other place		Date De		City or Town, State
saitimore,	nit. Pages Partmant of I ortant: If its Injury or o		1√ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Tremovariioni State	cemetery	on Forest Ve	et 2	2-12-04	Owings	s Mills, Md.
g Q	permit. P Departma Importan any Injur.		21. Signature of Funeral Service Lice	nsee Jan		22. Name and Addres		BaLTI	MORE, MC	1. 21202
		-	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the de	h. Do n	March F.I			E. North	Approximate
	Physician		shock, or heart failure. List only	one cause on eech line.				,		Interval Between Onset and Death
1	/Medical		tmmediate Cause (Final disease or condition			1	- 1 1 0			
	Examiner		resulting in death)	eDue to	(or as a co	onsequence of):	ner_			
	ed sit	nine		b						i
,	axecut an and nal-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)	Due to	(or as a co	onsequence of):				
09/90	w requiras thet tha death certificate be axecuted been signed by the attanding physician and should be datached for use as the bunal-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a co	onsequence of):				
XO	ding			d						
מ	attan I for u	ciar								1
j.	tha d by the achec	Physician/M	Part il. Other significant conditions of	ontributing to death but not re	esulting in	the underlying cause give	en in Part I.			tribute to the cause of death?  3. Probably 4 □ Unknown
Ŋ,	s thet med t	by P						101	fes 2□No	3 Probably 4 □ Unknown
	requiras thet tha death cent been signed by the attanding hould be datached for use	ted						24a. Was a	an autopsy med?	24b. Were autopsy findings avaitable prior to
Ž L	e law r has be	Completed			***					completion of cause of deeth?
0	n: Th ficeta x, pa		25. Was case referred to medical					1 U Y		1 Yes 2 No
>	sicia s certi	To Be	examiner?	Hospital: 1   Inpatient 2	□ FB/Outr	patient 3 DOA Othe	er: 4☐ Nursing Hon			or connected by an aire
5	g Phy er this serel o		27. Manner of Death	28e. Date of Injury (Month, Dey Year)	28b. Ti				ow injury occurre	11 11 1100 100
Sion	ath. r: Att	atio	1 ☑ Natural 5 ☐ Pending investigation	n			Yes 2 □ No			
Š	To the Nospital or Attending Physician: The law within 24 hours aftar death.  To the Funeral Director: After this certificeta has completaly filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Placa of Injury - At building, etc. (Spec	home, farr cify)	m, street, factory, office	2	8f. Location (S City or Tow		er or Rural Route Number,
/	spital hours neral y filled		29a. Certifier 12 Certifying Ph	ysician: To the best of my ki	nowledge,	death occurred at the tim	ne, date and place, a	nd due to the c	ause(s) and mai	nner as stated.
	the Ho nin 24 the Fu npletal	Medical	one)	niner: On the basis of examined menner steted.	nation end/					
	Con To Will		29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	(Month, Dey, Year)
	0	,	P phi im	~		1040	0554		2/9	2004
		'	30. Name and address of person wild	0-00	em 23e) (T	ype, Print)	0.03	\ n	-	
	Sta	6	31. Dete filed (Month, Day, Year)	32. Registrer's Sig	nature	L OCHUMO	12 d/d	USL		
	Registra	_	FFR 1 9 20	104 1	A. S.	Storage de				
_				The second secon						

			1 For	State of Ma	•		t of H	lealth a	and M	•	giene	2 n n i	. 01.216
_			Registrar		Ce	ertificate	e or L	Jeath		2. Date of Dea	Reg. No.	<u> </u>	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)	. W:11						Februar		Year 2004	7:15 Pi7
	/Medic		Rachel A		er	4h City	Town or	Location of		1 en unit	7	County of Dea	
	Examin	er	Keswick MultiCare			-		imore			40.0	N/A	
	Europel		5. Social Security Number 6. Sex		(In yrs. last birthda	) If Under	1 Year	If Under	24 Hrs.	8. Date of Birtl (Month, Day	1		thplace (State or Foreign ountry)
	Funeral Director			M 2√2√x	95 Yrs.	Months	Days	Hours	Min.	0ct. 4.			ountry) ryland
			Usual Residence of Decedent										· · · · · · · · · · · · · · · · · · ·
	how how		10a. State 10b. County		10c. City, Town or I	_ocation							10d. Inside City Limits
	e Ma	cto	Maryland N/A		]	3altim	ore						XXYes 2 No
:	death with the Maryland ms 23e or 28e-f show r must be halffied at	Director	10e. Street and Number			10f. Zip					10g. Citiz	en of What Co	ountry?
	ath w		4506 Keswick Roa				212					USA	
	er de	Funeral	11. Wantai States	12. Was Decedent E Armed Forces?		. Was Deced If Yes, spec	lent of Hi offy Cuba	ispanic Ori in, Mexican	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)	1.	<ol> <li>Race - Ame Black, White</li> </ol>	
36	hours after tural', or ite al Exemina	by F	1 ☐ Never Married 2 ☐ Married  3x☐xWidowed 4 ☐ Divorced	1 ☐ Yes 2/17/No If Yes, Give Year or Dates:		1 ☐ Yes 2	XXNo	Specify:			5	Specify:	white
2-0036	hou stura	ed t	15. Decedent's Educ		16a. Dec	edent's Usua	I Occupa	ation			16b. Kin	d of Business	
15	within 72 ene. then "net he Medici	plet	(Specify only highest grade		(Giv	e kind of wor DO NOT us	k done d	during most	t of workin	ng		timore	,
212	yiene r the	Completed	Elementary/Secondary (0-12)	2.	Nui	se- I	LPN						& Throat
٦	be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene. do other than "natural", or items 23e or 28e-f show event, the Medical Exam or must be multiped at	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	(umame)	
<u> </u>	Vid by Vi	ToE	Jesse Edward Y	ingling					Eff:	ie Tiab	itha	Smith	
Maryland	and P		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mai	ling Address	(Street a	and Numbe	er or Rura	l Route Numbe	r, City or	Town, State,	Zip Code)
	s 1 and 3 f Health item 27 other tr		Sarah Leah Spence	Daughte		Keswi				timore,			
ore .	ges 1 It of He If iter or oth		20a. Method of Disposition 1	emoval from State	20b. Place of Disp cemetery, cr						20c. Loc	ation - City or	Town, State
Ĕ	Pag ment ant:		*4 ☐ Donation 5 ☐ Other (Specify)		Meadow E					5/04	West	tminste	er,Maryland
Baltimore,	Depart Import any n		21. Signature of Funeral Service License		i	22. Name and	d Addres -Hens	s of Facilit	y itz I	Funeral	Home	a Inc	
	⊈ O E e O		stores H	argent	4 3	631 Fa	ills	Road	Ba	Funeral Ltimore	, Mai	ryland	21211
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused to e cause on each line	the death. Do not e	nter the mode	of dying	g, such as	cardiac oi	r respiratory arr	est,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	Kenal	e farle	vre							2 days
١,	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	A 1 0	,			1.0			
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	ara	con	rugo	pan	May			HOW HARD THE REAL
	led nsit	ulue	Cause (Disease or injury	Carron	1. A.L.	21 /02	,1 ,	ON	101				Maharas
_	be executed sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequence of):	n apo	y	uc	- WC	re			wymin
9	ysiciar ysiciar e buri	calE			U								
				•									
Rox	leath certificat attending phy I for use as th	N/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o 1 □ Live birth 2		□Ectopic pre					23	d. Date of de	livery
מ	the death certitica by the attending phace ached for use as the	icla	in the past 12 months?	4⊡Pregnant at ti		Other (spe						Month	Day Year
O	w requires that the de been signed by the should be detached	by Physiclan/Med	9 □ Unknown	9□ Unknown									
s i	The law requires that the has been signed boage 2 should be detained by	by	Part II. Other significant conditions con	tributing to death but	t not resulting in the	underlying ca	ause give	n in Part I.					the cause of death?
ב פ	equir sen si ould	ted								1 U Y	es 2 🕞	4No 3∐Pr	robably 4 □Unknown
Vital Records,	law r	Completed								24a. Was a autops	sy .	prior to	utopsy findings available completion of cause of
	G	Sol								perfor		death? 1 ☐ Yes	2 □ No
=======================================	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to edical examiner?	ospital:			Othe		of Death	(Check only or	ю)		
_	F SIC	2	1 Yes 2 No	28a. Date of Injury			^	4   411	and the second	ne 5 ☐ Reside 8d. Describe he			cify)
ב כ	ding Phys h. After this funeral dir	lou	1 Natural 5 ☐ Pending	(Month, Day	Year) Injury	ы 26 М	Bc. Injury Work	ai ? /es 2 □ !		bu. Describe in	ow inquiry	occaned	
<u>s</u>	death death ctor: / the	licat	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, s					8f. Location (Si	reet and	Number or Ru	ural Route Number,
Division	To the hospitel or Attending Piwithin 24 hours after death.  To the Funeral Director: After it completely filled in by the funera	Certification;	4 Homicide determined	building, etc.	(Specify)	,				City or Town	n, State)		
	spite nours neral		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, dea	th occurred a	at the tim	e, date and	d place, a	nd due to the c	ause(s) a	nd manner as	s stated.
	n 24 h	Medical	(Check only 2 Medical Examination)	ier: On the basis of e and manner state		nvestigation,	in my op	inion, deat	th occurre	d at the time, d	ate and p	lace, and due	to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier		\			number		2	9d. Date	signed (Monti	h. Day, Year)
	,		M Sobelle V	lac to	regar	13 D	13	657	_	1	ebru	eduy !	1,2004
1			30. Name and address of person who could be a supplemental of the	mpleted cause of dea	ath (Item &3a) (Type R, 700 K	Print)	4 57	REE	T, P.	DAL 770	70R	E, Mi	1,200 <del>4</del> 1,200 <del>4</del> ) 21 211
	Sta		31. Date filed (Month, Day, Year)	32. Registrar			-						
	Registra	ar	FEB 1 2 2004										

			1 = For State Registrar	State of Maryla	•	artment of H rtificate of L		ental Hygie Reg.	- 6 UUL	04317
			1. Decedent's Name (First, Middle, La	(st)	7-			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ALBERT	GEORGE 1	2241	R		EBRUARY		
	Examin		4a. Facility Name (If not institution, gin Saint Joseph	re street and number) Medical Ce	nter	4b. City, Town, or	Location of Death	n	4c. County of Deat Ball	timore
3	Funeral Director			Sex 7. Age (In yrs	s. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth 9. Birth 9. A.	hplace (State or Foreign buntry)
	D.		Usual Residence of Decedent	100 (	City, Town or L	anation.				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be rollited at	7	10a. State 10b. County		Ch os c	Cation				1 ☐ Yes 2 No
	he M	Director	10e. Street and Number	TORE	HORK	10f. Zip Code		100	Citizen of What Co	untry?
	with a or			To Con		212	1/0	109.	17 5 0	\
	leath ris 23	Funerai	8806 Wolve R	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
	after o		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1≱Yes 2 ☐ No		If Yes, specify Cubai		Rican, etc.)	Black, Whit	e, etc.
0000	hours after tural', or Ite	d by	3 Widowed Divorced	If Yes, Give Year or Dates KORS	A	TLI THS ZJEJ NO	Specify:		Specify: W	HITE
ה	72 h "natu	Completed	15. Decedent's E (Specify only highest gr		(Give	edent's Usual Occupa e kind of work done of	luring most of workii	10	o. Kind of Business	-
V	within 72 ene. then "na the Medic	dw	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,	Absa	1/2/	cc er #	133
N 0	Hygie Hygie Sther		17. Father's Name (First, Middle, Las		0030	175211-10	18. Mother's Name	(First, Middle, Mai		700
a	De de fa	To Be	TEESPH ME	458 1794	50		MIDREC	namo	HERRET	CHAHO
3	2 should and Mer is marke aumatic	_	19a. Informant's Name/Relationship			ing Address (Street a	and Number or Rura	Route Number, C	ity or Town, State, 2	Zip Code)
Ž	and 2 lealth a m 27 le		WILLARD ETTT	3/2/2	1900	Herer &	GAL RONC	CARGE !	MARYL	LEERE ONA
e G	of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 [		. Place of Disp cemetery, cre	osition (Name of matory or other place	SL FECT.	ate 200	c. Location - City or	Town, State
аппо	Pages nent of ent: If it ury or o		'4 □ Donation 5 □ Other (Speci		SET HI	Matthe MA	362	H' F	WHILLA	1964/00
ă	permit. Pages Department of I Importent: If it eny injury or o		21. Signal re of Funeral Service Lice	nse	2	2. Name and Addres	s of Facility	LESORTE	3 6	31234
מ	80 E E 8		MOST ALCO	8	\$	3800 HAR	FORD KOR	O HARK	17/5 1 HG	97800
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not en	iter the mode of dying	g, such as cardiac o	r respiratory arrest,	•	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIC		H LEG			-	2 DAYS
	/Medical Examiner		resulting in doctory	Due to (or as a conse RENAL FA						DAYS
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. HYPERTEN	SION					20 YEARS
ה`	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as a conse	equence of):					
0 0 0	cate be executed physician and the burial-transit	dicai	•	ARTERIOS	CLERO	ric card	IOVASCUL	AR DISE	ASE	20 YEARS
٥	death certificate e attending phys d for use as the	Med	IF FEMALE:	03- 16						
ž R R	attend attend for us	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of dei Month	ivery Day Year
j	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	rueam st					
Ţ.	that thed by deta	by Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the t	underlying cause give	an in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds,	w requires that the de been signed by the should be detached		CONGESTIVE HEA	RT_FAILURE				1 🔀 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Hecord	law red as bee 2 shor	ompleted	DEMENTIA					24a. Was an	24b. Were au	topsy findings available
	he he age	mo	DEMENTIA					autopsy performed 1 ☐ Yes 2 🔀	death?	completion of cause of
VII	ician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death	<del></del>		
>   	nysici nis ce I direc	To	examiner? 1 ☐ Yes 2 🔀 No	Hospital: Inpatient 2	☐ ER/Outpatie	int 3□ DOA Othe	9r: 4 ☐ Nursing Hor	ne 5 🗆 Residenc	e 6 Other (Spec	cify)
0 =	ng Pt Ifter th		27. Manner of Death 1 2 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	(?	8d. Describe how	injury occurred	
<u> </u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not	ne -			Yes 2 □No	201. 1 101		
Division	ist or Attending Physician: 1 s after death. sl Director: After this certificat ad in by the funeral director, p	Certification;	4 Homicide determined		home, farm, st cify)	treet, factory, office	4	City or Town, S	it and Number or Ru itate)	irai Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C		hysician: To the best of my ki miner: On the basis of examinated.						
	within To th compl	Me	29b. Signature and title of certifier	//		29c. License	number	29d.	Date signed (Monti	h, Day, Year)
	^		1			D Ø	018662	ón.	2/11/	04
	1		30. Name and address of person who	completed cause of death (It	em 23a) (Type	, Print)				
'Se-			WILLIAM H. GC	20 D Wh I . C'-	7601		RIVE TOV	ISON MAR	YLAND 2	1574
5	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	A. A.	porte				

			1 - For Amend Item 24a,	State of Ma 26 per Verb	ryland, OD/	12704ans ertificat	t of Header	alth and eath		giene Reg. No		+ 04318
			1. Decedent's Name (First, Middle, Last)						2. Date of De	ath Day	y Year	3. Time of Death
	Physici /Medio		Adora B. Moore						Janua	ny 2	27 200	
	Examir	er	4a. Facility Name (If not institution, give s			4b. City,	0 11	cation of Deat	h C	4c.	County of Deer	th
^			St. Agnes Healthca  5. Social Security Number 6. Sex		(In yrs. last birtho	fav) If Unde	00011	f Under 24 Hrs	8. Date of Bir	th	9 Rin	hplace (State or Foreign
	Funeral Director			7 - 4 - 577 -	87 Yr	Months	Days I	Hours Min.	Apr 3,	y, Year)	Co	vland
	ס		Usual Residence of Decedent								o indi	· · · · · · · · · · · · · · · · · · ·
	72 hours after death with the Maryland natural; or tlems 23s or 28s-f show digal Examiner must be notified at	_	10a. State 10b. County		10c. City, Town o	rLocation timore						10d. Inside City Limits
	18a-f	Director			Dai		0.1			10- 04	:4 Wh C-	
	with t		10e. Street and Number 1732 Ruxton Avenu	10		107. 21	21216	:		•	izen of What Co	ountry?
	ns 23	Funerai		12. Was Decedent E	ver in U.S.	13. Was Dece	dent of Hispa	anic Origin? (S	Specify Yes or No		USA 14. Race - Ame	
3	or Her on Her or		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 N	0			Mexican, Puer	to Rican, etc.)		Black, Whit	
5	ral', c	1 by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2⊠ No 5	ървспу:			Specify:	black
,		Completed	15. Decedent's Educ (Specify only highest grade	cation e <i>completed)</i>	(0		rk done duri	on ing most of wo	rking	16b. K	ind of Business	Industry
4	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	-) "	fe. DO NOT u	se <i>relirea)</i> sewife				um homo	
Maryianu z iz i3-0036	filed within I Hygiene. other than '		17. Father's Name (First, Middle, Last)			nou			me (First, Middle		wn home Sumame)	
0	Mental Mental arked o	To Be	William Herbert B	ailey				Este	lla Caut	ion		
y ir	2 should be and Menta la marked aumatic av	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. N	lailing Addres	s (Street and	d Number or Ri	ural Route Numb	er, City o	or Town, State, 2	Zip Code)
	is 1 and 2 of Health a itam 27 is other trai		Paul Moore/son		33	37 Dol:	field	Avenue	Baltimo	re,	MD 212	15
Dalilliore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place of D cemetery,	isposition (Na crematory or i			Date	20¢. Lo	ocation - City or	Town, State
Dair	permit. Page Department of Important: if any injury or		21. gnatu of kunera Service License ROD Ld S. V	Vade, Dire				of Facility My Boar 4D 212	d 655 W.	Bal	Ltimore	Street
	Pnysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	the death. Do not	enter the mo	de of dying, s	such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 48 Hours
	/Medical Examiner			D		moni	a					48 Hours
*24.0	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·		al Fc	brill	liation	n			48 Hours
8/60,	death certificate be executed to attending physicien and at for use as the buriat-transit	dicai Ex	resulting in death) Last	Due to (or as a	consequence of)	:						
0	eath certifice attending ph for use as th	/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o	of pregnancy						23d. Date of de	ivery
O. Box	that the death hed by the atter detached for u	Physician/Me	in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{No} \) No  9 \( \text{Unknown} \)	1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown		3 □Ectopic p 5 □ Other (s					Month	Day Year
ds, P	luires that n signed b	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in th	ne underlying	cause given i	in Part I.		obacco ( Yes 2	_	o the cause of death?
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed							24a. Was auto perfo 1 Yes		prior to	itopsy findings available completion of cause of
Ea		Ф	25. Was case referred to medical				20	6. Place of De	ath (Check only o		1 100	20110
	ysici is ce direc	To B	examiner? 1 ☐ Yes 2 📉 No	lospital: 1 🔀 Inpatier	nt 2 ER/Outp	atient 3 D	OA Other:	4 Nursing H	dome 5 ☐ Resi	dence	6 □Other (Spe	cify)
Ion of	fing After fune		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	Year) 285. Tin Inju	ne of ury M	28c. Injury at Work? 1 ☐ Yes	t s 2 □No	28d. Describe	how inju	y occurred	
DIVISION	el or Attanos s after death il Director: id in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm (Specify)	i, street, factor	y, office		28f. Location (. City or To			ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examin	sicien: To the best o ner: On the basis of and manner stat	examination and/	death occurred or investigation	at the time, n, in my opini	date and place ion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as I place, and due	s stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29	c. License n	umber		29d. Da	te signed (Mont	h, Day, Year)
			* Kachel Sher	nasmo			P156	27		Jar	nuani	27,2004
			30. Name and address of person who co	ras MD	900	(pe, Print)	m F		Baltime	ne	MD 2	21229
		ate	31. Date filed (Month, Day, Year) FEB 12 2004	32. Registra	r's Signature	West of					· · · · · · · · · · · · · · · · · · ·	
100	Regist	rar	I PR T W FOOT	4								

			1 - State Amend Item 26 po	State of Mer Verb.,G8	aryland / De 28,02/12/04	epartment of l	Health a	and Mental Hy	giene	2004	04319
			Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of Death
	Physici /Medio		Ronald F. Mallo	у				Janua	Day ry 27		1:30 P M
	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town,	or Location of	of Death	4c.	County of Death	
			92 Mt. Pleasant S			Frosth		24 Hes 0 6 4 B		Allega	
	Funeral		5. Social Security Number 6. Se	x	ge (In yrs. last birtho 59 Yr	Months Dave		Min. (Month, D	a <i>y, Year)</i>	Cou	plece (State or Foreign ntry)
404	Director		217-42-6385 Usual Residence of Decedent					Dec 6,	1944	Mary	Land
	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23e or 28a-f show in Madical Examinat must be rediffed at		10a. State 10b. County MD Allegan		10c. City, Town of						10d. Inside City Limits
	a-1 s	ctor	MD Allegan	ıy	Fros	tburg					1 ☐ Yes 2X No
	or 28	S.	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	eth w	Funeral Director	92 Mt. Pleasant			215				USA	
	er de Item	nue	11. Marital Status 1 □ Never Married 2 Amarried	12. Was Decedent Armed Forces? 1 \( \text{Yes} \) 2 \( \text{Z} \)	Ever in U.S.	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Original Dan, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 1	<ol> <li>Race - Ameri Black, White,</li> </ol>	
5	I, or	by F	1 □ Never Marned 2 PMarned 3 □ Wildowed 4 □ Divorced	If Yes, Give Year or Dates:	NO	1 ☐ Yes 2 💆 No	Specify:			Specify: W	nite
ş	2 hou	ed	15. Decedent's Edu	cation	16a. D	ecedent's Usual Occu	pation		16b. Kir	nd of Business/Ir	ndustry
2	nin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	- //	live kind of work done fe. DO NOT use retire	du <i>ring</i> most d)	t of working			
Z	giene giene er the	E O	12	0		truck d	river		tı	ransport	ation
2	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)	-				r's Name (First, Middle			
Z Z	Meni Meni arke	၉	Francis Leo Mal					via Laverne			
Maryland 21215-0036	l 2 sh and remm		19a. Informant's Name/Relationship (T) Margaret Clark/si	-		-		or or Rural Route Numb			o Code)
a,	1 and Heelth em 27 ther t		20a. Method of Disposition	ster 		.U4 Royal ( isposition (Name of	Dak Dr	ive Cumber		MD 21 cation - City or T	502
Baitimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 show any injury or other traumatic avant, the Maridal Experient must be radified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ※ Donation 5 ☐ Other (Specify)			crematory or other pla	(08)		200. 200	oution only or i	Own, 51515
Dall	permit. Depart Import any inj once.		21. Signal re of Euro al Service Licens Runald S	Tad Dir	ector	State Anat Baltimore,	ony B	oard 655 W 21201	. Bal	timore S	Street
S			23. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused	d the death. Do not						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		sclerotic	Condido	11/2/11	las Dis	P(1 ( p		Onset and Death
	/Medical		resulting in death)		a consequence of)	Coracio	DICICA	acc	w.y.		-years.
	Examiner		Sequentially list conditions	b							
	De iii	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)						
	ate be executed thysicien and the burial-transit	Examiner		Due to (or as	a consequence of)						
/60,	be exiction puris	cal E									
200	ficate phys s the			đ							
X	w requires that the death certifica been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		- 0-			2	3d. Date of deliv	ery
P.O. Box	death e atte d for	cla	in the past 12 months?	4 Pregnant a	2 Fetal death time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			Month	Day Year
j.	t the by the ache	hys	9 Unknown	9□ Unknown							
	s tha	by P	Part II. Other significant conditions co.	8 4	1.2	e underlying cause gr	ven in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
ğ	en sig		Dilated Co	udiomy	to pathy			10	Yes 2	No 3□Prol	bably 4 Dunknown
Records,	law re as be 2 sho	Completed						24a. Was		24b. Were auto	opsy findings available impletion of cause of
Ĭ	sicien: The lav certificete has rector, page 2	E O	Released					perf 1 ☐ Yes	ormed? 2 X No	death? 1 ☐ Yes	2∭ No
E	striffic ctor.	Be (	25. Was case referred to medical					of Death (Check only			
>	hysic his ce I dire	Tol	1X Yes 2□ No	lospital: 1 Inpatie		III III III		rsing Home 5 X Res	idence 6	Other (Specia	<i>(y)</i>
_ _	ng P	ino ii	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 28b. Tim ıy Year) 1nju	ry Wo		28d. Describe	how injury	occurred	
<u> </u>	tendi leath. tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 ☐ î				
DIVISION OF VITAL	after d Direct	Certification;	4 Homicide determined	28e. Place of Inj building, et	lury - At home, farm ic. <i>(Specify)</i>	, street, factory, office			Street and wn, State)	d Number or Run	al Route Number,
_	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Co	(Check only 2 Medical Exami	ner: On the basis o	f examination and/o	eath occurred at the ti or investigation, in my	me, date and	d place, and due to the	cause(s) a	and manner as s	stated. the cause(s)
	ithin 2 tha mple	Med	29b. Signature and title of certifier	and manner st	ateu.	29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	F 2 5 8		Worker	Eshi.	Mn		5532	.5		27,20	
					teath (Itam 22a) (T		_		VIUN	1 27,20	- 1
			30. Name and address of person who co	MD A	-6 Terana	Terrico	F	sthure	Mno	1530	
1	Sta	ite	30. Name and address of person who co WONSOCK SHIN 31. Date filed (Month, Day, Year)	32 Registr	rar's Signature	And a	V **C	31.200		1774,	
	Regist		EER 1 9 200	34 /	and the f	THE CL					
DH	MH 17 Rev 1/2	001	PED 12 CO.	*			-				

ORIGINAL

V THOMAS 1. Decedent's Name (First, Middle, Last)

5. Social Security Numberunk 6. Sex

213-09-7177

10e. Street and Number

10a, State

Director

MD

Usual Residence of Decedent

31. Date filed (Month, Day, Year)

FEB 1 2 2004

State

Registrar DHMH 17 Rev 1/2001 Thomas Meekins

4a. Facility Name (If not institution, give street and number)

12038 Philadelphia Road

10b. County

12038 Philadelphia Road

Harford

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or Items 23a or 28a-f show the Mudical Examiner must be notified at Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. maintenance worker 6th unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Meekins Irene Spence 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) at of Heam.
at: If item 27 is Gloria Clements/sister 103 Warfield Road Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 🖾 Other (Specify) in state permit. Page Department of Important: If any injury or once. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signatur Funeral Strylice Licensee Ronal d S. Wade, rector Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterioscleratic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially its, conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death jo in the past 12 months? 5 Other (specify) I□Yes 2□No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been signated 24a. Was an performed 2 XNo 1 Yes certificate 25. Was case referred to medical examiner?

1 ▼Yes 2 □ No 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther 4 Nursing Home 5 Nesidence 6 Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 28b. Time of 27. Manner of Death Injury 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 018667 who completed cause of death (tem 23a) (Type, Print) 6 Trumble Hill CT. Litherville Maryland Militello MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5, 78,15 per anatomy board 8845,716,05 yt or State of Maryland Department of Health and Mema Hygiene

7. Age (In yrs, last birthday)

10c. City, Town or Location

Joppa

88

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

21085

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Joppa

10f. Zip Code

2. Date of Death

Feburery

2

Oct. 20, 1915

Month

3. Time of Death

636 P

10d. Inside City Limits

Approximate Interval Between Onset and Death

10 years

1 ☐ Yes 2 ☑ No

Birthplace (State or Foreign Country)

Maryland

Year

2004

4c. County of Death

...Harford

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Month

black

city of Baltimore

USA

Specify:

32 Registrar's Signature

				State of Maryla					_		
		•	1 - For State Registrar	Otato of Maryta		rtificate of			2001	+ 04321	
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death	
	Physicia		BERNARD	JOSEPH	-/ 1	VENBER	RUFR	- FEBRU	ARY 7 200	12:05 pm	
	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town,		1011100	4c. County of Dee		
	LAdimiii	C1	HARBOR HOSPIT	AL CENT	ER	BALT	IMOR	Ē	n/a		
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Dete of Birl Min. (Month, Da	h 9. Bir	thplace (State or Foreign	
	Director		219-10-5491	M 2□F 78	Yrs.	Working Days		Jan.06	1926 Ma	ryĺand	
	p		Usuel Residence of Decedent  10a, State 10b, County	10c (	City, Town or Lo	ocation				10d. Inside City Limits	
	anyla ehon	۲	Md. Baltimore		Baltim					1 ☐ Yes 2 No	
	the N	Director	10e, Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?	
	with B or	<u>a</u>	1842 Dunmere Road			212	22		U.S.		
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow exical Ensuline must be motified at	Funerai		2. Was Decedent Ever in	U.S. 13.	Was Decedent of	Hispanic Orig	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Am		
		Ē	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 □ No If Yes, Give				Puerto Rican, etc.)		white	
3	ial', d	by	3 XWidowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🗓 No	э эрөспу:		Specify:	wiiice	
9500-61212	within 72 hours after ene. than "natural", or Ite he Wedical Erranine	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	16b. Kind of Business	/Industry	
7	ithin 16.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	$^{ extit{DO NOT use retire}}  ext{olice of}$	<sub>ed)</sub> ficer		Baltimore	City	
	led w lygier her ti		12 17. Father's Name (First, Middle, Last)	0 ==	1 -	01100 01		r's Name (First, Middle,		•	
Maryland	be fi	Be	Bernard Josep	h Newbe	erger	Sr.	E11.		Fraas		
Ž	should and Men marke	2	19a. Informant's Name/Relationship (Type				and Number	r or Rural Route Numbe	er, City or Town, State,	Zip Code)	
<u>s</u>	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		Kathleen H. Daven						, Md. 21222		
ō,	Heal Hem 2 tem 2		20a. Method of Disposition	20b	. Place of Dispo	osition (Name of	****	Date	20c. Location - City of	Town, Stete	
<u></u>	0 = 5		1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State C	edar Hi	matory or other pl. 11 Cemet	ery 0	2/12/04	Baltimore	, Md.	
Baitimore,	. 5 3 3		21. Signature of Funeral Service License	622	/ 2	2. Name and Addi	ress of Eacility	/: -la Eumana	1 II D A		
n	permit Depart Import eny in		Silver of	Dollmu	de /	237 E.	Pataps	co Ave. ba	l Home P.A.	. 21225	
. 5	CIMIL		23a. Part1. Enter the disease, or compli- bock, or heart failure. List only on	unons that a used the de						Approximate Interval Between	
3	Physician		Immediate Cause (Final							Onset and Death 4 day C	
	/Medical		resulting in death)	Due to (or as a cons	equence of):	CC TTPT	-UT PC	119		Taugs	
			Commence the first committees of the	(ARDE	Ac	ARREST	-			4 days	
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):						
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
760,	cien a		resulting in south, East	Due to (or as a cons	equence or):						
687	cate b	dicai					···				
9 ×	death certificate e attending phy id for use as the	Physician/Med	IF FEMALE:	3c. if yes, outcome of preg	nancv				23d. Date of de	divery	
Box	atten for u	lan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etel death 3	☐Ectopic pregnan☐Other (specify)	су		Month	Day Year	
o.	0 0 0	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown							
٦.	uires that the de signed by the a id be detached f	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions						obacco use contribute	ute to the cause of death?	
rds	quires n sign	d b						152	Yes 2□No 3□F	robably 4 Unknown	
၀	The law requires that the tee has been signed by the bage 2 should be detache	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of	
Re	The lav te has	E						perfo	rmed? - death?		
a		BeC	25. Was case referred to medical				26. Place	of Death (Check only of	•		
>	nysic nis ce direc	Tof	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	ther: 4 🗆 Nu	rsing Home 5 🗆 Resi	dence 6 Other (Sp.	ecify)	
0	ng Ph fter th ineral		27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	ork?		how injury occurred		
S 0	tendi eath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes 2 ☐ No			Street and Number or Rural Route Number,		
Division of Vital Records,	il or Attending P after death. Director: After t d in by the funera	Certification:	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, larm, si ecify)	reet, lactory, office	9	City or To		urai Houte Number,	
	pital ours a eral C		29a. Certifier 1 Certifying Phys	sician: To the best of my k	raciwladae dea	th occurred at the	time date an	d place, and due to the	cause(s) and manner a	s stated	
	Hos 24 ho Fun elely	Medical	(Check only 2 Medicel Examination)	ner: On the basis of exam and manner stated.	ination and/or in	nvestigation, in my	opinion, deal	th occurred at the time,	date and place, and du	e to the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mor	th, Day, Year)	
•	1/1		I Litrul also	ewold 1	M.D	RES	100		February	7.2004	
	1041		30. Name and address of person who co		tem 23a) (Type	, Print)			-	7,2004 molimo2121	
	1		HERT CHERKE	vold 3	001 ST	OTH H	ANOVE	R STRE	ET BAUTS	molimo 2/24	
	Sta		31. Date liled (Month, Day, Year)	32. Registrar's Sig	ture	4					
	Regist	rar	FEB	1 2 2 204	Jan But	H. Jon	ASL.				

			1 - For State Registrar	State of Mai		artment of H			iene 20	04	0432	2 6						
	Physic /Medi		1. Decedent's Name (First, Middle, Last,	rzein.				2. Date of Death Month FEBRUAR	Day	Yeer 2004	3. Time of Dear 16:52	h M						
	Examiı		4a. Facility Name (If not institution, give JOHN HOPKINS BAYV	TEW HOSP		BALTI			4c. County	A								
	Funeral Director		5. Social Security Number 6. Security Number 218-12-2002	7. Age	(In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan . 29	Year)	Count	ace (State or For ry) y land	эign ——						
	e Maryland	ctor	Md . 10b. County		10c. City, Town or Lo Baltin						od. Inside City Lin							
	3a or 2	al Dire	1341 Hull Street			10f. Zip Code 2123	30	10	0g. Citizen of W		ry?							
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Evantinet must be routilled at	d by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 【又Divorced	12. Was Decedent Ev Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:			spanic Origin? (Spen, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	14. Race	America k, White, e	tc.							
Baltimore, Maryland 21215-0036	ad within 72 h rgiene. er than "natu r, the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired aretaker	furing most of worki	ng	16b. Kind of Bu Housewi		· ·							
yland	ould be fill Mental Hy tarked oth	To Be	17. Father's Name (First, Middle, Last) $Floyd \qquad H.$	Jacobs			18. Mother's Name Doroth	у Е.	•	Ways								
Mar	alth and 2 sh		19a. Informant's Name/Relationship (Ty Edward P. Ochrzc	The same to the sa			un <i>d Number or Rur</i> a reet, Bal		-		Code)							
imore	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, tha Meone.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		Glen Have	matory or other place	al Pk.02/		Glen B	-								
Balt	permit. Departi Import any Inj		21. Signature of Funeral Service License	110x 4:2 -121	Ecker 22	MCCull MCCull 130 E.	y-Polynia Fort ave	k Funera . Baltim	al Home	D.A.								
	Physician /Medical Examiner	_	23a. Part. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a	oselero				-		Approximate Interval Between Onset and Death							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last		consequence of):													
.O. Box 6	at the death certifica by the attending phatached for use as the	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	y Day Year							
Δ.	quires that n signed b uld be deta	by	by	by		by	by	by	Part II. Other significant conditions cor	tributing to death but	not resulting in the u	nderlying cause give	n in Part I.		_	bute to the	cause of death?	
of Vital Records,	The law requirate has been spage 2 should					Hey potypord			-		24a. Was an autopsy perform	red? d	rior to com eath?	sy findings availa pletion of cause	ble of			
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	-3	• 35 DOA Othe	26. Place of Death		·									
		ıtlon: To		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day )	28b. Time of Injury	28c. Injury Work	4 Li Nursing Hon	ne 5 Resider 8d. Describe how									
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm. street, factory, office building, etc. (Specify)					fice 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one)	ician: To the best of ner: On the basis of e and manner state	xamination and/or in	vestigation, in my op	inion, death occurre	ed at the time, dat	te and place, a	nd due to t	he cause(s)							
	£ 5 5 5 € 7	~	29b. Signalure and title of commier	and		29c. License	667	0	d. Date signed	200	4							
			30. Name and address of person who co	mpleted cause of dea	10 Ritchi	Print) 2 Higher	3 508 C	lou Born	uy Mary	land	21061							
	Sta Pogisti	ite	FFR 1	9 2004	- L	1 10	٠.											

Please Type of Print in Black Indelible link. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 2004	01.00
Contilinate of Dooth	7.040

	For State Registrar	State of Maryla		rtificate of			Reg. No.	U4 U432.	
ian ical	Decedent's Name (First, Middle, Last)  Lora Alma	Owens				2. Date of De Month Februa	Day Day Ery 9, 20	Year 3. Time of Death 12:50 P M	
iner	4a. Facility Neme (If not institution, give s			4b. City, Town, o	or Location of Dea	ith	4c. County	of Death	
	Franklin Square Ho			Rosedal	e If Under 24 Hr			more County	
	228-28-1339	7. Age (in y	rrs. last birthday Yrs.	Months Days	Hours Mir		ay, Year)	9. Birthplece (State or Foreign Country) Maryland	
	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits	
ō	Maryland Baltimor	· F	astpoin	<b>-</b>				1 ☐ Yes 2 XNo	
Director	Maryland Baltimor  10e. Street and Number	e L	ascpoin	10f. Zip Code			10g. Citizen of V	Vhat Country?	
	7941 Wynbrook Road			21224			U. S. A		
Funerai		12. Was Decedent Ever in	n U.S. 13.	Was Decedent of I	dispanic Origin? (	Specify Yes or No	o- 14. Race	e - American Indian,	
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		If Yes, specify Cub  1 ☐ Yes 2 ☒ No		no nican, etc.)		k, White, etc.	
d by	3 X Widowed 4 ☐ Divorced	Year or Dates:		1 163 2 A 140	эрвспу.		Specity	White	
Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	edent's Usual Occup s kind of work done	during most of w	orking		isiness/Industry	
mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	(d)		Baltimo	ore County	
	17. Father's Name (First, Middle, Last)		Cust	odian	18 Mother's Na	me (First Middle	School  Maiden Sumam	<del>_</del>	
Be								<b>-</b> ,	
2	Lawrence Hargr 19a. Informant's Name/Relationship (Ty)		19b. Mail	ing Address (Street	Dura  and Number or F	Parker		State, Zip Code)	
	Ronnie Owens, Sr.	(Son)					, , , , , , , , ,	Maryland 21220	
	20a. Method of Disposition		b. Place of Disp	osition (Name of		Date		City or Town, State	
	1 A Burial 2 □ Cremation 3 □ R  1 4 □ Donation 5 □ Other (Specify)		-	matory or other pla	1 2	2/11 2004	Daltimor	re, Maryland	
	21. Signature of Funeral Service License			2. Name and Addre	-	2004	Datcinor	e, Maryranu	
	Michael 65	" Mars 5"	B	ruzdzinsk 407 Old H	i Funera	l Home I	PA	aryland 21221	
			eath. Do not er	nter the mode of dyi	ng, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between	
Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiliated events	Due to (or as a con:		Winselen	OTIC CA	rraso Va	SCIPE Y CHISTA	re.	
edicai	resulting in death) Last	Due to (or as a cons							
Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	ast 12 months?  s 2/3No  O D Hokepower  S as 12 months?  4 Pregnant at time of death 5 Other (specify)						e of delivery nth Day Year	
by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death		
Completed							psv a	Nere autopsy findings available prior to completion of cause of leath? Yes 2 \( \) No	
Be	25. Was case referred to medical examiner?	lospital:		O+	hac	eath (Check only			
<u>ا</u>	1 √ Yes 2 No ''	1 Inpatient 2	ZER/Outpatie	MIC 3LI DOA	4 Nursing	*	idence 6 Othe	- ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	
no	1 Natural 5 Pending	(Month, Day Year	r) Injury	Wo	rk? ]Yes 2 □No	26d. Describe	how injury occurr	<del>o</del> d	
Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.			163 2 100		(Street and Number own, State)	er or Rural Route Number,	
Medical C		sician: To the best of my ner: On the basis of exam and manner stated.							
Me	29b. Signature and title of certifier			29c. Licen.			•	1 (Month, Day, Year)	
	30. Name and address of person who co	mpleted cause of death (			enn Stre	et Ralt	imore N	Maryland 2120;	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

			1 - For State Registrar	State of Ma		ertificate of Dea	th	Reg. No.	4 04324		
	Physicia		Decedent's Name (First, Middle, La     Theodore	st)	Pendle	ton	2. Date of D Month FEB	Day Ye			
}	/Medical Examiner 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Locati		4c. County of E				
		ŭ.	GOOD SAMARITA	N HOSPIT	AL	BALT	TIMORE	Na			
	Funeral Director		5. Social Security Number 248-72-5581 6. S	M 2□E	(In yrs. last birthda) 59 Yrs.	Months Days Hou	nder 24 Hrs. 8. Date of B irs Min. (Month, I 10-9	Day, Year)	Birthplace (State or Foreign Country)  N.Y.		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation			10d. Inside City Limits		
	Manyl fed a	ō	Md. NA		Baltim	ore			1√2 Yes 2 □ No		
	r 280	Directo	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	t Country?		
	th with		1107 Ramblewood	Rd.		21214		U	SA		
	r dea	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or Nican, Puerto Rican, etc.)	No- 14. Race - A	American Indian, Vhite, etc.		
36	be filed within 72 hours after death with the Maryland tal Hyglene d other than "neturel", or Items 23a or 28e-f ehow event, the Madical Examinational be motified at	by F.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 N If Yes, Give X Year or Dates:	lo	1 ☐ Yes 2 ☑ No Spec		Specify:	Black		
5-003	P hour	edt	15. Decedent's E	ducation	16a. Dec	edent's Usual Occupation		16b. Kind of Busine			
1215	within 72 ene. than "net	Completed	(Specify only highest gri	ade completed)  College (1-4or 5-	(Giv	e kind of work done during r DO NOT use retired)	most of working		,		
21	filed wit Hygiene other the	Co	12th grade			urity		Varie	s		
Maryland 2	be fill d oth	Be	17. Father's Name (First, Middle, Last	)		18. M	lother's Name (First, Middi	le, Maiden Surname)			
<u> </u>	d 2 should be th and Menta 17 Is marked traumatic ev	ို	John 19a. Informant's Name/Relationship (	Tuna Print)	Wilson	ling Address (Street and My	Sarah	Glov			
Z	12 s h ar h ar 7 is trau		Earl S Pendleton	Brothe		ling Address (Street and Nu					
ē,	+ <b>₹ ₹</b>		20a. Method of Disposition	BLOCITE		7 Ramblewood position (Name of ematory or other place)	Date	20c. Location - City	21214 or Town, State		
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			mel Cem.	2-13-04	Dundalk,	Mď.		
Baltimore,	permit. Pages Department of Important: If i any injury or c	Ì	21. Signatur 1 Funeral Service			22. Name and Address of Fa	acility Balt	imore, Md.	21202		
<u> </u>	89 = 89		I plessof y	a		March F.H. Ea		l E. North			
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):								
			Sequentially list conditions,	INMPHOMA							
-	po tis	iner	rany, leading to ammediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of).						
	and I-trans	Examiner	that initiated events resulting in death) Last	c. AV	a consequence of);						
, 60	ificate be executed g physicien and as the burial-transit										
68760	ificate g phy: as the	edicai		. 0.							
P.O. Box	Attending Physician: The law requires that the death certif redeath. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the composition of the com	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of Month	delivery Day Year		
a.	s that ned by deta	y Ph	Part II. Other significant conditions	tobacco use contribut	co use contribute to the cause of death?						
g	w require: been sig should be	ed b	HYPOGLYCE	MIA, M	1ALNUT	RITION	1	Yes 2∐No 3∐	] Probably 4 🗷 Unknown		
ပ္ပ	e law re has bev ge 2 sho	Completed by					24a. Wa		24b. Were autopsy findings available prior to completion of cause of		
m —	ysician: The l is certificate ha director, page	Com					per 1 ☐ Yes	formed? deat	h? Yes 212 No		
ita Ita	ılclan: Th certificate rector, paç	Be (	25. Was case referred to medical examiner?				Place of Death (Check only	one)			
ot	Physi this c al din	J.	1 Yes 2 10 No 27. Manner of Death	The state of the s	nt 2 ER/Outpati		Nursing Home 5 Re		Specify)		
Division of Vital Records,	l or Attending Ph after death. Director: After th in by the funeral	Certification:	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury			Describe how injury occurred			
/Si	Atten	fica	3 Suicide 6 Could not b	e 28e. Place of Inju	ıry - At home, farm, s	196.30.00	28f. Location	Location (Street and Number or Rural Route Number,			
á	el or s after il Dire	Serti	4 ☐ Homicide building, etc. (Specify)					own, State)			
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying P	nysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the time, date nvestigation, in my opinion,	e and place, and due to the death occurred at the time	e cause(s) and manne e, date and place, and	r as stated. due to the cause(s)		
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. License numb		29d. Date signed (M			
•	^		Michel Ka	fromi, MI	>	RES	000	FEB 0	9,2004		
	78		30. Name and address of person who				HARITAN A				
			MICHEL KAFR 31. Date filed (Month, Day, Year)	OUNI, MI	ar's Signature	5601 LOLH	LRAVEN BLY	& BALTIM	ORE, HD 21239		
	Sta Registr	- 1	TED 10 7	E.		ereli					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) February 87,2004 **Physician EDNA** NAOMI REICHERT 7:00 P M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Co. Regency Park Assisted Living Gambrills If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🔯 F Director 212-10-1464 March 30 1911 Maryland Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mouleal Example crust be multiled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Howard Co. Woodstock Md. Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2153 Turn Berry Way 21163 ILS.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carlton Johnson Edna Men1y 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Reichert Jr. (Son) 2153 Turn Berry Way, Woodstock, Md. 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 02/11/04 Baltimore, Md. 21. Signature of Funeral Service Licenses McCully Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 23a. Part 1. Enter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ammediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner TO Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been significated to page 2 should to 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify Hospital: 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA Diractor: After that in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D37111 0 Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATEL, 605 H Mm o NDS W V 6 BALTIMORE MD21225 32. Registrar's ignature 31. Date filed (Month, Day, Year) State Registrar FEB 12 200

		1 - For Amend Item 24a		-/ 12/06	чинсате	e or L	Jean	2. Date of D	Reg. No	The last of the	0 % 0 4
Physicia	an	Decedent's Name (First, Middle, La	st)					Month	Da	y Year	3. Time of De
/Medic		SUSIE	12095					rebru	7.	4,200	
Examin	er	4a. Fecility Name (If not institution, give	4			Town, or	Location of Dea	- (	4c.	. County of Deet	
			tosp ITAL		FAN	-DAL	ر می می کار			BALT	
Funeral Director		192-10-4027	7. Age (In yrs.)	ast birthday) Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min	(Month, D	rth ay, Year)	21 9. Birth Co	hplece (State or Funtry)  JA
which 72 rous after beath with the maryland than "natural", or lieme 23s or 28e-1 show than "natural", or lieme 23s or 28e-1 show he Medical Examiner must be notified at		Usuel Residence of Decedent  10a, State 10b, County	10c. Cit	, Town or Lo	cation						10d. Inside City I
ital Hygiene. od other than "natural", or lieme 23a or 28e-1 ehow event, the Madical Examiner must be notified at	5										1 ☐ Yes 2
8	Director	MD Balti	nore Pi	kesvi		0.4			40- 04	inne of 1145 - 1 Co	
- E	ă	10e. Street and Number			10f. Zip				Tug. Cit	tizen of What Co	•
23a	æ	728 Milford M	T				21208			U.S.	
E E	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced If Yes, spec	lent of His lify Cubar	spanic Origin? (5 n, Mexican, Puei	Specify Yes or No to Rican, etc.)	0-	<ol> <li>Race - Ame Black, White</li> </ol>	
P를	Ē	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes	XXVo	Specify:			Specify: 1	Black
E M	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:								
nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usua kind of wor	il Occupa rk done d	tion uring most of wo	orking.		ind of Business	
. us.	d d	Elementary/Secondary (0-12)	College (1-4or 5+)		_						Count
Hygiene. other than	S	9th grade	na	Ma	inte					nool S	ystem
nd Mental Hyge marked other matic event,	Be	17. Father's Name (First, Middle, Last		Unkno	wn		18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
Mental arked o	٥						Lucill	e Bumb	rey		
le me	1	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address	(Street a	nd Number or R	ural Route Numb	er, City o	or Town, State, 2	Tip Code)
27 l		Harvadene Gust	us-Daughter	728	Milf	ord	Mill F	Road, P	ikes	sville	Md 21
I Heath and Men Item 27 Is marke other traumatic		20a. Method of Disposition	20b. P	lace of Dispo	sition (Nam	ne of	1	Date		ocation - City or	
1: 10		1√ Surial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	Removal from State			-		/10/04	Rat	ndallet	town, M
Department of Importent: If eny injury or once.								10/04	Nai	idalis	LOWITY PI
Department of the function of		21. Signature of Funeral Service Lice	nsee	M	arch	F/F	s of Facility I West				
3 = 0 a		Maca IV	arch	4	300 1	Waba	ash Ave	, Balt		re Md	21215
		23a: Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not ent	er the mode	e of dying	, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Atheroscle	40	1	-din	lace	or D	C 12 m	CO	Onset and Dea
edical		resulting in death)	a. Due to (or as a consequ		Car	prioc	77400	~ /	(year	-70	
miner											
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (u. as a cunsequ	ence of).		-					
nsit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
al-tra	Xa	resulting in death) Last	c.  Due to (or as a consequ	uence of):							
attending physician and for use as the burial-transit	calE										
the		•	_ d								<del></del>
ing F e as	Me	IF FEMALE:		7	- 6116						
tend or us	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pre	egnancy				23d. Date of del	
the at hed fo	200	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of de 9☐ Unknown		Other (spe				Ì	Month	Day Yea
a o	h.	9 Unknown	3CI OTIKITOWIT						ļ		
igned be det		Part II. Other significant conditions	contributing to death but not resu	alting in the u	nderlying ca	ause give	n in Part I.	23e. Did	tobacco u	use contribute to	the cause of deat
n sig	Ď	Viabetas	Mentos	<u> </u>				1 🗆	Yes 2	□ No 3 □ Pr	obably 4 Dunk
been s	lete							24a. Was	200	24h Were au	topsy findings ava
has ge 2	Completed by							auto		prior to death?	completion of caus
cate pag	ပိ		,					1 ☐ Yes	2 <b>X</b> No		2 No
is certificate ha	Be	25. Was case referred to medical examiner?				17.		ath (Check only	one)		
this c	ို	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2X	ER/Outpatier	nt 3 DO	A Othe	r: 4 🗆 Nursing I	Home 5 ☐ Res	idence	6 □Other (Spec	cify)
ter th		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	f 28	8c. Injury Work	at ?	28d. Describe	how injur	ry occurred	
1 A	Certification:	1 Natural 5 Pending 2 Accident investigation		,	М		es 2 □No				
oy th	if	3 Suicide 6 Could not be determined	286. Place of injury - At no	me, farm, sti	eet, factory,	, office					ral Route Number
Dir	ert	4  Homicide	building, etc. (Specify	")				City or To	wn, State	9)	
To the Funeral Director: Atter completely filled in by the funer		29a. Certifier Certifying P	nysician: To the best of my kno	wiedne deat	h occurred a	at the time	e date and plac	e and due to the	Cance(c)	and manner as	stated
To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	miner: On the basis of examinal and manner stated.	ion and/or in	vestigation.	in my op	inion, death occ	urred at the time,	date and	place, and due	to the cause(s)
mple	Mec	29b. Signature and title of certifier	and manner stated.		200	. License	oumber		20d Dat	te signed (Monti	Doy Your
2 0		250. Signature and this of certifier		1.5	290.	. Liverise	70	-	and Dai	to signed (Month	, Dey, 18a1)
		- Maria	100	MC	>	258	5775	>	44	12004	
h			completed cause of seath (Item	23a) (Type,	Print)			-		,	
フ		KERITH JOSE	rt MD 5401	000	COUF	7-	RD RA	NDAUS	TOWN	J, MD:	2(133
Sta Registr		KERITH JOSE  31. Date filed (Month, Day, Year)  EER 1 2 //11/4	PH MD 5401 32. Registrar's Signa	000		7	RD RA	NDAUS	tous	J, MD:	2(1)

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary	•	tificate of		•	Reg. No. 2	INL NL3	27
	Physici	an	1. Decedent's Name (First, Middle, Last		EID			2. Dete of De Month	path Day	3. Time of De	ath
1	/Medi	cal	4a Fecility Name (If not institution, give		. 41	T	4h City Town o	r Location of Deet	10 h 4c. County	04 0 an	1
1	Examir	ier		0 0	NH:	-	Balto		4c. County	N/A	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi	s. 8. Date of Bir	th v. Year)	Birthplace (State or Fo Country)	oreign
	Director		217-01-0649 Usuel Residence of Decedent	□M 2X□F 9	5 Yrs.			8-5-		Md	
	show		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City L	imits.
	72 hours after death with the Merylend natural, or fleme 23e or 28e-f show dical Evandrer must be motified at	ctor	Md	N/A	Balto					1 XYes 2	□No
	4 th	Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	
	9ath v	erai	1808 N. Payson St		in 11 6   12 1	2121		(Casalta Van an Na	U S	A e - American Indian,	
0	fler d	Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ YNo				Specify Yes or No into Rican, etc.)	Blac	ck, White, etc.	
21215-0020	ours af	þ	3 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Detes:	1	I□Yes 2□XNo	Specify:		Specify	<sup>c</sup> Black	
15-0	netu	Be Completed	15. Decedent's Edu (Specify onfy highest grad	cation le completed)	16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retire	ation during most of w	orkin <b>g</b>	16b. Kind of Bu	usiness/Industry	
12	within ene.	dmo	Elementery/Secondary (0-12) 10th grade	College (1-4or 5+) N/A			a)		Pri	vate Homes	
	e filed other vent,	ပိ	17. Father's Name (First, Middle, Last)	N/A	) ДС	omestic	18. Mother's Na	ame (First, Middle,	Maiden Sumam	ne)	
ylar	should be nd Mente marked	ToB	John Cagle				Anni	e Ross			
Maryland	2 sho ls me reum		19a. Informant's Name/Relationship (T)	1177				Rurel Route Numb			
	ss 1 and of Health Itam 27	1	Burnetta A. Pars		ZZ41  Ob. Place of Dispos	Penrose	Avenue	Balto, M		City or Town. State	
Baltimore,	nit. Pages 1 and 2 should be filed within the filed within the filed the filed between the filed		1   Burial 2 □ Cremation 3 □ F  Donation 5 □ Other (Specify)	Removal from State	cemetery, crem	natory or other plac	*			,	i
Ħ	Demit. Page Depertment of mportant: if any injury or ance.	1	21. Signature of Funeral-Service Licens		T	Mem Park Name and Addre		2-13-04    March Eas			202
Ä	Depending of the series of the	1	1 Something	K- Inn	es)				•	e Balto, Md	. 202
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that gaused the decause on each line.	death. Do not ente	or the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between	n
	Physician /Medical				. 1	- 0	1	- 1		Onset and Deat	th
	Examiner		Immediate Cause (Final disease or condition resulting in death)	Athero			diova	Sculer	Desea	10	
		Je.		Due	to (or as a consequ	uence of):				,	
	icate be executed physicien and s the buriel-transit	Examiner	Sequentially list conditions,	Due :	to (or es a consequ	uence of):					
60,	be exe cien a buriel-	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
68760,		8	that initiated events resulting in death) Last	Due t	to (or as e consequ	ence of):					
	anding use ex	Physician/M		1							
. B	The law raquiras that tha death cen ata has been signed by the attendin paga 2 should be datached for use	sicia	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause giv	en in Part I.	23b. Did 1	obacco use con	ntribute to the cause of de	eath?
P.0	d by that datach	문						10	Yes 2□No	3 Probably 4 Onk	nown
ds,	signe d be d	d by						Ode Mee		24b. Were autopsy findin	
Records,	v raqu been shou	ete				_		perfo	an autopsy med?	available prior to completion of cause	
Re	he lav ta has aga 2	Completed						453	es di es	of death?	
			25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)	12 163 22-110	
<u>~</u>	Physician: this certific ral director,	ို	1 ☐ Yes 2 ☐ No		2 ER/Outpatient		4 Nursing	Home 5 ☐ Resid	lence 6 🗆 Othe	r (Specify)	
n C	Te age	ü	27. Manner of Deeth  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	. 28c. Injun Worl	y et k? Yes 2 □ No	28d. Describe h	ow injury occurr	∌d	
/isi	Attending ir death. sctor: Attei by tha funa	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - A	At home, farm, stre		163 2 140	28f. Location (S	Street and Number	er or Rural Route Number,	_
ă	al or s s eftar al Dire	Certification:	4 Homicide	building, etc. (Sp	ecify)			City or Tow	m, State)		
,	To the Hoapitsi or Attending Phys within 24 hours etter death.  To the Funarel Director: After this completely filled in by the funarel d		(Uneck only 2   Medical Examin	ician: To the best of my ner: On the basis of exam	knowledge, deeth	occurred at the timestigation, in my of	ne, date and place pinion, death occ	e, and due to the ourred at the time, o	cause(s) and mai	nner as stated. and due to the cause(s)	
	ithin 2 o the	Med	one) 29b. Signature and title of certifier	end manner stated.		29c. License				(Month, Day, Year)	
	-		Drogat Al	7	MD	DUT	405	-	2/12/	04	
	<b>X</b>	Y :	30. Name end eddress of person who co	mpleted cause of death (	(Item 23a) (Type, P	rint)	/ 0 0	+	1121		
			LIARAT AL	1 8211	1-Eut	aw st	Bal	timore	MD	21201	
	Stat Registra		31. Date filed (Month, Dey, Year)	32. Registrar's Si	ignature						

DHMH 16 Rev 6/95

Please Type or Print in Black Inde lible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Physician February 07,2004 07:29AM essie /Medical 4a Fecility Name (If not institution, give street end number 4b. City. Town, or Location of Deeth . 4c. County of Death Examiner Beltimore City Johns Hopkins Hospital The If Under 24 Hrs. 8. Date of Birth (Month, Dayl Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country)
 S.C. **Funeral** Days 1 ☐ M 2 🖫 F VIS Director 248-58-1794 69 Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Directo Md. NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filad within 72 hours after death with ò Неть 23а 21213 USA Funerai 2233 E. Federal Street 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: Black \$ 3 ☐ Widowed 4 ☐ Divorced "naturai". Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Villa Maria Housekeeping 12th grade other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mantel H lant: if Item 27 Is marked oth Anderson Carrie Milledge Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Health Important: if Item 27 James Rowe Husdand 2233 E. Federal St., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State Mt. Calvary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2-13-04 Anne Arundel Co., Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 any Ir March F.H. East 1101 E. North Ave. Oresa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (of as a consequence of): Physician/Medical Examiner ate has been signed by the attanding physician and page 2 should be detached for usa as the burial-trensit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): Obstru Box 68760. Due to (or as a consequence of) 016 Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Š Be Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate : After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 100 Certification: To 1 Inpatient 2 X R/Outpatient 3 □ DOA 27. Menner of Deeth 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 TYes 2 No death. 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 052507 NO 30. Name end address of person with complete use of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

FEB

600 N

MD

2 2004

32. Registrar's Signature

	•	For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of H	lealth and Death		giene 200	+ 04329
		Decedent's Name (First, Middle, Last)			<del></del>		2. Date of Dea		3. Time of Death
Physici		Price Ro	binson,	Jr.			Februar	ry 9, 2004	8:00 P M
/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Dee	th	4c. County of Dea	th
	•	Home; 8410 Bodkin	Avenue		Pasad	lena		Anne Art	ınde1
Funeral		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	h 9. Bir	thplace (State or Foreign ountry)
Director		234-20-3037	M 2□F	81 Yrs.			Jan. 3	, 1923 Wes	t Virginia
D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
sho	_				Pasadena				1 □ Yes 2 ☑ No
he M 18a-1	ecto	Maryland						10g. Citizen of What C	
with th	Dir.	10e. Street and Number 8410 Bodkin Avenue	ř		10f. Zip Code	21122		Tog. Citizen or venat C	USA
filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or thems 23a or 28a-f show ent, the Medical Examination that be invitibled at	Funeral Director		12. Was Decedent E	war in H.C. 12.1	Vac Danadant of H		Specify Ves or No.	14. Rece - Am	
ttem Terr	n.	11. Marital Status  1 ☐ Never Married 2 ▼ Married	Armed Forces?		Yes, specify Cuba	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, Whi	
rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:1		☐ Yes 2/CXNo	Specify:		Specify: V	hite
tura	edi	15. Decedent's Edu		16a. Deced	lent's Usual Occup	ation		16b. Kind of Business	/Industry
n ne	Completed	(Specify only highest grad	e completed) College (1-4or 5-	life. L	kind of work done OO NOT use retired	during most of wo d)	orking		
iene jene r tha	E	/i	College (1940) 34		ness owne	er		Self emp	loyeed
illed Hygi other	BeC	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·		18. Mother's Na	me (First, Middle,	Maiden Sumame)	
lental ked o ic sve	ToB	Price Robinson	, Sr.			Bess	ie Hutch:	inson	
2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than 'natural', or frems 23a or 28a-f show aumatic event, the Medical Examinat must be indiffied at		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	g Address (Street	and Number or F	iural Route Numbe	er, City or Town, State,	Zip Code)
alth a		Inez Robinson	(Wife)	8410	Bodkin A	venue	Pasadena	, Maryland	21122
es 1 a of Hei of Item r othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Location - City of	Town, State
Pages nent of int: If it		1x□x8urial 2 □ Cremation 3 □ F  1x□x8urial 2 □ Cremation 3 □ F	lemoval from State	Maryland	Veteran	Cem. 2/	18/04	Garrison H	orest, MD
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic <u>QDCB</u> .	100	21. Signatur Funeral Service Licens	MIDO IN	1 B	Name and Addreurgee-Hei	ss of Facility nss-Seit s Road	z Funera Baltimore	l Home, Inc e, Maryland	21211
Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or complishock, or heart fallure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a	Hodgh	er the mode of dyir	lg, such as cardia	phow	rrest,	Approximate Interval Between Onset and Death
ificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of);					
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	olivery Day Year
quires that n signed by		Part II. Other significent conditions co	ntributing to death bu	at not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute i	o the cause of death? robably 4 \(\sum \text{Unknown}\)
The law requir cate has been si page 2 should l	Completed						24a. Was autor perfo 1 Yes	rmed? prior to death?	utopsy findings availabl completion of cause of s 2 \sum No
Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					eath (Check only o	_	
physic this ce al dire	10	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatier	t 3□ DOA Ott	er: 4 🗆 Nursing	Home 5 President	dence 6 Other (Sp.	ecify)
Jing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	28c. Injui Wor	y at		now injury occurred	
or A lifter Direction or by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, farm, str :. (Specify)	eet, factory, office		28f. Location (: City or Tox	Street and Number or F vn, State)	lural Route Number,
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical			examination and/or in				cause(s) and manner a date and place, and du	
To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mor	th, Day, Year)
-		Mark	ans w	, D	D3	9505		ebruari	+ 10, 2006
6		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type,	tal Dr.	Glen	sumi'	e, MD.	21061
Sta Regist	ate rar	31. Date filed (Month, Day, Year) FFB 1 2 2004	32. Registra	ys Signature	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 0433 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day Month **Physician** Jc. County of Deeth Charles Robinson rebruary 1306D /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HOSPITAL Many and 5. Social Security Number General 8. Date of Birth (Month, Dey, Yeer) Aug 24, 19 If Under 1 Year | If Under 24 Hrs. 7. Age (În yrs. lest birthdey) Birthplecs (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Days Hours 44 Yrs. 213-78-3407 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location item 27 is marked other than "neturel", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at MD Baltimore 1X Yes 2 No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 909 Pennsylvania Avenue 3B 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: þ black. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cab driver transportation permit. Peges 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Item 27 is marked other y injury or other traumatic event, pdgs. 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Robinson Nellie Buchanan 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nellie Anderson/mother 619 George Street #4 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☒ Other (Specify) in State Balti State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Euneral Service Licenses Ronald S. Wades Director menny. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. evere Hyper Kalemia Due to (or as a consequence of): Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition Physician severe. resulting in death) /Medical Renal Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) the death certificate be executed Septic Shock
Due to (or as a consequence of): burial-translt attending physician and P.O. Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) be detached å 9 Unknown 9 Unknown ğ The law requires thet signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Monknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed certificate 1 Yes 2 No 1 Yes 2 No Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 8950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

catherine

31. Date filed (Month, Day, Year)

FEB

1 2 2004

108U100

Registrar's Signature

to Maryland

		•	For State Registrar	State of Ma		Depa		t of H	ealth a		lental Hy		_	0433
	sicia edica		Decedent's Name (First, Middle, Last     Charles Rus				-				2. Date of D Month	Day	7, 200	04 11:10 11"
	mine eral	er	5. Social Security Number 6. Se	Sing H	1 <u> </u>	oirthday) Yrs.	4b. City, /-/QL If Under Months	rea	If Under:	RAC	8. Date of Bi (Month, D Jan 17	( 4c.	County of D	
p		tor	Usual Residence of Decedent  10a. State 10b. County MD Harford		10c. City, To		cation e Gra	ce		,				10d. Inside City Limit
with the 3e or 28a		Funeral Director	10e. Street and Number 415 S. Market Str	eet	L		10f. Zip	Code 2107	- <del></del> 8			10g. Citiz	en of What	
be filed within 72 hours after death with the Maryland tall Hygiene. To other than "netural", or Itema 23e or 28a-1 show awant the Maryland Reserving the puritiest and the second the Maryland Reserving the puritiest and the second the Maryland Reserving the puritiest and the second the Maryland Reserving the puritiest and the second the Maryland Reserving the puritiest and the secon	EVEL IN BELLIN	ਨੂ∣	11. Marital Status  1 X Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1		lent of Hi of Cuba		gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)			merican Indian, hite, etc.
nd 2 should be filed within 72 hours att Illh and Menial Hygiene "27 la marked othar than "netural", or trainmaits about the Menice Franch	Manage St.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5		a. Deced (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired,	ition Juring most	t of work	unk <sub>ing</sub>		of Busine	
2 should be filed and Mental Hygin Is marked other	anc avent	To Be C	17. Father's Name (First, Middle, Last) James Russe	11					18. Mothe		e (First, Middle gia Ad	, Maiden :	Sumame)	
s 1 and 2 should if Health and Mer item 27 la marke			19a. Informant's Name/Relationship (T)  Betty Cheek/niec		20b. Place	97 I	Kings	Way		e No	al Route Numb ortheas Date	t, MD	2190	1
Page nent o	ilany or		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☒ Other (Specify)	in state		ery, crer	natory or or	ther place						or Town, State
permit. Departr	any is	_	21. Signature of puneral Services Licens 23a. Part 1 Enter the disease, or comp	Wined	the death D	ра	TCTIIC	ne,	rid 2	2120.	<u>L</u>		timore	2 Street Approximate
Physici /Medic Examin	cal	Examiner	shock)or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	i me	Lu mo	e of):								Interval Between Onset and Death
ifficate be executed g physician and as the burial-transit	9	ical Ex	that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):	-							
The law requires that the death certification the has been signed by the attending phy age 2 should be detached for use as the	מושפת וכו מפש ש	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal dea		Ectopic pre					2	3d. Date of o	delivery Day Year
w requires that been signed by should be detailed.		2	Part II. Dther significant conditions co	ntributing to death bu	ut not resulting	in the u	nderlying ca	ause give	n in Part I.		23e. Did		,	to the cause of death?  Probably 4 □Unknown
icien: The law r certificate has be	hager	e Completed	25. Was case referred to medical						00 Plan	- ( D 1)	24a. Was auto perfo 1 Yes	psy ormed? 2 No	24b. Were prior t death	
ling Phys After this		90	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	dospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day) 28e. Place of Inju	y Year) 28b	Time of Injury	M 2	8c. Injury Work 1 🗆 Y	r. 4 Nui	rsing Hor	me 5 Resi	dence 6 how injury	occurred	pecify) Rural Route Number,
To the Hospital or Attency within 24 hours after death To the Funaral Diractor:	in mean in		29a Certifier 18 Certifying Phy	building, etc	of my knowled	an death	- Cocurred	at the tim	e, date and	d place of	City or To	wn, State)	and manner	as stated
To the Ho within 24 t To the Fu		Medical	(Check only one)  2 Medicel Exami  29b. Signature and title of certifier	ner: On the basis of and manner sta	examination a	ınd/or inv	estigation,	in my op License	inion, deat number	h occurre	ed at the time,	date and p	place, and d	nth, Day, Year)
Reg	Stat gistra	е	30. Name and address of person who con Sering Chin (31. Date filed (Worth, Day, Year))  FEB 1 2 20	mpleted cause of de 3 i 9 and 32. Registra	SOUT r's Signature	) (Type,		Av	055 mu		Havne	de	Sruce	17004

DHMH 17 Rev 1/2001

GUSSELL, CHARLES

		•	For State Registrar	State of Maryland			e of D			Reg. N	6 U L		332
F			1. Decedent's Name (First, Middle, Last)						2. Date of Month	Death Da	av Yea	3. Time of	Death
<b>N</b> eile	Physicia /Medic		EDWARD EUGENE	SCRIBNER JR					Febr	north	08 20		-5 M
)	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City,	Town, or L	ocation of De	ath	4	c. County of De	ath	
1			UNION MEMORIAL H				ALTIMO	ORE If Under 24 H	rs 9 Data of	Dieth	N/A	introduction (CA-A-	
	Funeral Director		5. Social Security Number 219-02-3924  Usual Residence of Decedent		4 Yrs.	Months		Hours Mi	s. 8. Date of (Month,	Day, Year	7	irthplace (State of Country) MARYLAN	
	land ow	ł	10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
	Mary First	to	MARYLAND N/A		BALTIM	ORE						1∭Yes	2 🗌 No
	death with the Maryland ms 23a or 28a-f show	Directo	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What	Country?	
	23a (23a (		5610 LOTHIAN RD A	PT 1			2121	2		U	.S.A.		
	ours after death with the Marylan rai', or Itama 23a or 28a-f show East tither rount be rectified at	Funeral	Tr. Marker States	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	S. 13. \	Was Deced	dent of Hisp city Cuban,	anic Origin? Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - Al Black, W	nerican Indian, nite, etc.	
9	hours after tural', or Ita	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give		1 🗆 Yes	2⊠ No	Specify:			Specity:	BLACK	
	ž 3 7	ed b	15. Decedent's Educ	Year or Dates:	16a. Deced	dent's Usua	al Occupation	on		16h	Kind of Busine		
Ċ	within 72 ho ene. then "netur ne Mudical	Completed	(Specify only highest grade	completed)	(Give		rk done dui	ring most of w	rorking	, , , , ,		our induction y	
		E O	Elementary/Secondary (0-12)	College (1-4or 5+)	SECU	JRITY	GUARI	D		S	ECURITY	7.	
and	be filed tal Hygi d other event,	Be C	17. Father's Name (First, Middle, Last)				1	8. Mother's N	ame (First, Mid	dle, Maide	n Sumame)		
	should b nd Menta marked umatic e	10 8	EDWARD E SCRIBNER	SR.				COR	A JEAN	HALEY			
Mary	2 sho and l		19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailir	ng Address	(Street an	d Number or i	Ru <i>rai Route N</i> u	mber, City	or Town, State	, Zip Code)	
	s 1 and f Health Item 27 other tr		Terrell Lewis-Bey					Rd., A		+			2
0	8°= 5		20a. Method of Disposition  1 XX urial 2 ☐ Cremation 3 ☐ Re		ace of Dispo emetery, cren	natory or o	ne of other place)	İ	Date	20c. l	_ocation - City	or Town, State	
	permit. Pag Depertment Important: any injury once.		*4 □Donation 5 □Other (Specify)					ARK 02	-14-04	BA	LTIMOR	MARYLA	ND
g	permit. Departn imports any inju		21. Signature of Funeral Service License	Jowell	W]	CLLIA		ROWN CON AVEN		Y FUN	ERAL HO	ME P.A.	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ent	er the mod	le of dying,	such as cardi	ac or respirator	y arrest,		Approximat Interval Bet	ween
) F	Physician		Immediate Cause (Final disease or condition	PCP Pn	eumo	prior						Onset and	3.1
	/Medical Examiner		resulting in death)	Due to (or as a consequ		,							
	- Adminion	_	Sequentially list conditions, b	Due to (or as a consequ		1000.	5i 5	arcon	16			one m	Mina
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C1 1 (		Ohr	cess					mea	nonth
	axecu and al-tra	хаг	that initiated events c. resulting in death) Last	Due to (or as a consequ		HUS	CES.	5		_		onen	DOTTY
9/60	death certificate be executed e attending physician and id for use as the burial-transit	dical E											
89	uficat g phy as the	edic											
XOR	leath certifica attending pl	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetel		Ectopic pr	vonsnov				23d. Date of d		
E	a deal	sicia	in the past 12 months?	4 Pregnant at time of de 9 Unknown		Other (sp				-	Month	Day '	Year
r Ö	at the de d by the a etached	Phy	9 Unknown						00. 5				
Ś	requires that the een signed by th hould be detache	by	Part II. Other significant conditions con	tributing to death but not resu	liting in the u	naeriying c	ause given	in Part I.	- 1	∏ Yes 2		to the cause of o	
Vital Records,	w requir been si should	Completed								-			
ec ec	e la has je 2	du l								/as an utopsy erformed?	24b. Were prior t death	autopsy findings o completion of c	available ause of
<u></u>	Thate are								1⊠,Ye	s 2 N		es 2 No	
=		Be c	25. Was case referred to medical examiner?	ospital:	F0/0 4 4 4		Othan		eath (Check or		. 50: 45		
ō	g Physical this heral di	. To	1 ☐ Yes 2 ☑ No	28a, Date of Injury	ER/Outpatien 28b. Time of		28c. Injury a Work?	4   Nursing	Home 5 ☐ F		occurred ⊔Other (S	oecity)	
0	ading th. : After e funer	ij	1 XNatural 5 ☐ Pending investigation	(Month, Day Year)	Injury	м		s 2 No					
Division of	il or Attendi after death. I Director: A d in by the fu	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factor	y, office			n (Street a Town, Stat		Rural Route Num	ber,
2	safte safte al Dir ed in	Certification:	4 [ ] Homeob	building, etc. (Specify	,				Ony or	TOWN, SIZE			
	e Hospital or Attending 24 hours after death. e Funeral Director: After letely filled in by the fune	Medical	29a. Certifier 1 Certifying Phys (Chack only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred vestigation	at the time, , in my opin	, date and pla nion, death oc	ce, and due to curred at the tir	the cause( ne, date ar	s) and manner and place, and d	as stated. ue to the cause(s	3)
0	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				c. License r					nth, Day, Year)	
			▶ manestasi	L, MD		A	T 24	3894	6-010	Fe	broay	,08,20	400
	2		30. Name and address of person who co-	mpleted cause of death (Item	23а) (Туре,	Print) N	Inhan	Mohe	ebtash		•		
	0		201 E. Driversity	LKON I DOLL	undie	ML	212	18					
75	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's fignal	ture Som	Kal							

December from (First Advances)   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date   2 Date of Date				1 - For State Registrar	State of M	laryland		rtment of tificate of				ene 20	04	04333
## Septiment of Country of Dame of Country of Dame of		Physici	an	Decedent's Name (First, Mid	idle, Last)						Month		Year	
State   Substitution   Control   Con							Sad	er		F€	eb. 7	2004		08:49 a <sup>M</sup>
Description of the property of	7	Examir	ıer	4a. Facility Name (If not institut.	ion, give street and number	cal S	vst			of Death		4c. County o	f Death	
### Part   Part														
Company   Control   Cont					455M 2□E					Min.			9. Birthp Cour	place (State or Foreign htry)
100. Same 100. County 100. Same 100. County 100. County 100. County 100. Same 100. Sam		Director				29	115.			No	v. 1,1	974	Ma:	ryland
Security Company   Compa		and			ity	10c. City,	Town or Lo	cation			<del></del>		1	Od. Inside City Limits
Security Company   Compa		daryl f sho	ō											
Security Company   Compa		the 1	ec		Baltimore			10f Zin Code	Pa	rkvill		o Citizen of Wi	nat Cour	ntn.2
Security Company   Compa		with of a	ā		h			Ton. Zip oddo	21224		"			•
Security Company   Compa		eath	era			nt Ever in U.S.	13 1	Vas Decedent of			Ves or No-	T		
Secretary   Secr		ter d	Ę		Armed Forces	s?				, Puerto Rica	in, etc.)			
Secretary   Secr	2	urs a			If Yes, Give	•	1	☐ Yes 2☐ No	Specify:			Specify:	wh	ito
Secretary   Secr	Ş	2 hou		15. Decede	ent's Education		16a. Deced	ent's Usual Occu	pation		1	6b. Kind of Bus		
17. First Name (Prof. Mords, Land)  Dale E. Sadler  Dale E. Sadler  Dale E. Sadler  Dale E. Sadler  198. Maling Address (Stress and Number or Rural Rouse Number Coly or Town, State, Zp Coos)  Mr. Dale E. Sadler  Significant of Deposition (Number of Rural Rouse Number or Rural Rouse Number Coly or Town, State, Zp Coos)  Mr. Dale E. Sadler (Father)  200. Read of Deposition (Award of Deposition (Number of Rural Rouse Number Coly or Town, State, Zp Coos)  Mr. Dale E. Sadler (Father)  200. Read of Deposition (Award of Deposition (Number of Rural Rouse Number Coly or Town, State, Zp Coos)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Pro	7		pie		T	r 5+1	(Give . life. L	kind of work done OO NOT use retire	during most ed)	t of working				
17. First Name (Prof. Mords, Land)  Dale E. Sadler  Dale E. Sadler  Dale E. Sadler  Dale E. Sadler  198. Maling Address (Stress and Number or Rural Rouse Number Coly or Town, State, Zp Coos)  Mr. Dale E. Sadler  Significant of Deposition (Number of Rural Rouse Number or Rural Rouse Number Coly or Town, State, Zp Coos)  Mr. Dale E. Sadler (Father)  200. Read of Deposition (Award of Deposition (Number of Rural Rouse Number Coly or Town, State, Zp Coos)  Mr. Dale E. Sadler (Father)  200. Read of Deposition (Award of Deposition (Number of Rural Rouse Number Coly or Town, State, Zp Coos)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  1. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. District Significant Colors (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Prof. Mords)  2. Mords (Pro	Z	d with	ĕ		, College (1-40)	34)	Fu	rniture	Insta	ller		Furni	ture	e
Date E. Sadler    Date		oth vent,	O	17. Father's Name (First, Middle	e, Last)				18. Mother	r's Name (Fi	rst, Middle, M	aiden Sumame	)	
The Maining Address (Sines and Number of Poor Town, State 2 Code)  Mr. Dale E. Sadler (Father)  200. Method of Desposition (Marry Land 21234  201. Dale G. Sadler (Father)  202. Method of Desposition (Marry Land 21234  203. Method of Desposition (Marry Land 21234  204. Date of Desposition (Marry Land 21234  205. The Committee of Date of Desposition (Marry Land 21234)  206. Method of Desposition (Marry Land 21234)  207. Sequentially of the Marry Land 21234  208. Date of Desposition (Marry Land 21234)  209. Method of Desposition (Marry Land 21234)  209. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  201. Sequentially in the disease of Desposition (Marry Land 21234)  202. Sequentially in Desposition (Marry Land 21234)  203. Marry Land 21234  204. Method of Desposition (Marry Land 21234)  205. Method of Desposition (Marry Land 21234)  206. Method of Desposition (Marry Land 21234)  207. Method of Desposition (Marry Land 21234)  208. Date of Gentley (Marry Land 21234)  209. Method of Desposition (Marry Land 21234)  209. Method of Desposition (Marry Land 21234)  209. Method of Desposition (Marry Land 21234)  209. Marry Land 21234  209. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  200. Method of Desposition (Marry Land 21234)  207. Method of Desposition (Marry Land 21234)  208. Date of Desposition (Marry Land 21234)  209. Method of Desp	<u>a</u>	Aent:		Dale E. Sad	ler				Va	lerie	J. Bak	er		
Bursal 2 (Screenation 3 (Johns (Septenby))   1   1   1   1   1   1   1   1   1		and l		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin	g Address (Stree	t and Number	r or Rural Ro	ute Number,	City or Town, S	tate, Zip	Code)
Bursal 2 (Screenation 3 (Johns (Septenby))   1   1   1   1   1   1   1   1   1	_	and 2 salth n 27 I er tre		Mr. Dale E.	Sadler (Fath					ve. P	arkvil	le, Mar	ylar	nd 21234
Physician (Medical System)   Physician (Medic	<u> </u>	of He of He fiten			2	20b. Plac	e of Dispos	sition (Name of atory or other pla	ice)	Date	2	0c. Location - C	ity or To	wn, State
Physician (Medical System)   Physician (Medic	Ĕ	Page nent int: Ir				♥			- 1	2/11/	2004	Towson	. Ma	arvland
Physician (Medical System)   Physician (Medic	a	mit. portr y inju		21. Signature of Funeral Service	e License		22	Name and Addre	ess of Facility	v	11 200		-	
Prinyscian  Modical  Examinor  Prinyscian  Modical  Modical  Modical  Prinyscian  Modical  Modical  Prinyscian  Modical  Modical  Prinyscian  Modical  Mo	מ	8978		Just Co	Van		79	22 Wise	Ave.	Dunda	le of D	undaik, rvland	212	22
Private   Priv				23a Part1. Enter the disease, shock, or heart failure. La	omplications that cause	ed the death.	Do not ente	r the mode of dy	ng, such as o	cardiac or res	spiratory arres	st,		Approximate
Due to (or as a consequence of):	. 1	Physician		Immediate Cause (Final										
State  State  Sequencially list conditions, if ally, sequence or programs are consequence or programs of the control of the co	}	/Medical			_ a			<u> </u>	1	5				
The following of the part of t		Examiner		Convention lint conditions	Cervic	al Sp	ine 1			/				
The following of the part of t	-	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequer	nce ot):	R	IFIC	/				
FEMALE   23b. Was december of pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1		ocuter nd trans	ami	that initiated events	C			ure	-ON	ROV		ARTON OF THE STREET		
FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12	Š	e exe		resulting in death) Last	Due to (or a	s a consequer	nce of):			YE	DICAL			
FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   23d. Date of delivery   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12 months?   25d. Was decedent pregnant in the death of the past 12	2	ate b hysic he bu	ca		d						EXAMIN	5/		
230. Was decedent pregnant in the past 12 months? 1   Yes 2   No 3   Probably 4   Month Day Year  1   Yes 2   No 3   Probably 4   Month Day Year  1   Yes 2   No 3   Probably 4   Month Day Year  24a. Was an autopsy performed? 25. Was case referred to medical examiner:  25. Was case referred to medical examiner:  26. Place of Death (Check only one)  27. Manner of Death Injury at Month, Day Year)  28a. Date of Injury at Month Day Year  29b. Signature and title of seath?  29c. License number  29c. License number  29d. Location (Street and Number or Rural Route Number, Check only one)  29d. Signature and title of seath?  29d. Signature and title of seath?  29d. Date of Injury at Home, farm, street, factory, office  29d. Signature and title of seath?  29d. Date of Injury at Home, farm, street, factory, office  29d. Signature and title of seath?  29d. Date of Injury at Home, farm, street, factory, office  29d. Signature and title of seath?  29d. Date of Injury at Home, farm, street, factory, office  29d. Signature and title of seathers. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day Year)  30. Name and seases of person who completed cause of death (Item 23a) (Type, Print)  29d. Signature and title of seathers. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)  29d. Date signed (Month, Day Year)	Õ	ing pl	Med	IF FEMALE:	1					· ·			0	_
State   Stat	õ	th ce tendi	an/l	23b. Was decedent pregnant				Ectopic pregnanc	v			23d. Date	of delive	Y
238. Did toolece use continuous to the cause of death   1   1   1   1   1   1   1   1   1		0 0 0	Sici	1 ☐ Yes 2 ☐ No		at time of deat	h 5□	Other (specify) _				Monti	1	Day
238. Did toolece use continuous to the cause of death   1   1   1   1   1   1   1   1   1	ζ.	d by i	Phy											
State   Stat	ń	res th	by	Par II. Other significant condi	tions contributing to death	but not resultir	ng in the un	derlying cause gr	ven in Part I.					
State   Stat		requi	ted							— III	1 L Yes	2 ∐ No 3	Proba	abiy 4 🔼 Unknown
25. Was case referred to medical examiner?    State	သ	law lasb	ple									24b. We	re autop	psy findings available
25. Was case referred to medical examiner?    State	ב =	The ate h page	Son								performe	ed? dea	ath?	
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	<u> </u>	clen: artific ictor,	a						26. Place	of Death (Ch	eck only one)			
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	_	hysik his o	0		1 🔲 inpati		VOutpatient	3□ DOA Ott	ner: 4 🗌 Nur:	sing Home	5 🗆 Residen	ce 6 □Other	(Specify	)
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	=	ing P	ë.					28c. Inju	rk? 🛵	Sul	Describe how	injury occurred	1.F. R	IN MAIN
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	2	eath.	cati	2√ Accident inves	stigation 9-5-2	003 0	2125	2_M 1□	Yes 24 N	40				
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	<u> </u>	or At ther d irect n by	Ę		mined 28e. Place of In	njury - At home etc. <i>(Specify)</i>	, farm, stre	et, factory, office		28f. L	ocation (Stre	et and Number State)	or Rural	Route Number,
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	3	rato led i	ပ္	1	1					PHIL	HINE LIGHT	M. SSO	0	J COPPE NAME
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	,	Hosp 14 hou Fune tely fi	ical	(Uneck only 2 Medica	II Examiner: On the basis of	of examination	dge, death and/or inv	occurred at the ti estigation, in my o	me, date and opinion, death	place, and on the place of the	fue to the cau	se(s) and mann e and place, and	er as sta due to	ated. the cause(s)
30. Name and autress of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature		the thin 2 the mple	Med	5/16)	and manner's	tated.								
30. Name and audiess of person who completed cause of death (Item 23a) (Type, Print)  Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 31. Pate filed (Month, Day, Year)  32 Registrar's Signature	•	5 ± ₹ 5	-	250. Orginature and little to smill				P177	25		Fe	$b \cdot 9$	200	4, rear)
Ronald J. Nold Jr. Md, 22 S.Greene St. Balto, Md 21201  State 3. Date filed (Month, Day, Year)  32 Registrar's Signature		1												
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		6		2/1/2/				•	22 -	~				
		-0:			r) soffeet	J. NO	La Jr	. Md,	22 S.	Green	e St.	Balto	, M	ld 21201
							500	Les de la constitución de la con						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year February 10 -2004 Jehhette paraco 10-2004 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number Examiner If Under 24 Hrs. B. Date of Birth (Month, Day, Baltimore StellA Mari If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 PF 213-54-42 40 Usual Residence of Decedent Yrs. Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Balti mose ummonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. or items 23a 1624 Ka Rd Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ZHO
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry thand Mantal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Kestaurant 17. Father's Name (First, Middle, Last) To Be HENrietTA MOST iam Son Jarmit. Pegas 1 and 2 shr.
Department of Haalth and N.
Important: If Item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) mayRd 1624 Kape Essex md 21221 Brown Sister Da cily A 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn cemetery 2-13-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis Jr. 2007 Eastern Ave Balto md. complications List only one caus at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CERVICAL CANCER Examiner Due to (or as a consequence of) by Physician/Medical Examiner eral Director: After this certificate has been signed by the attanding physicien and filled in by the funeral director, pege 2 should be detached for usa as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes ZXNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient edicai Certification: To 1 ☐ Yes 2 X No 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 NOther (Specify) HOSPICE 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 C Homicide within 24 hours a To the Funeral C

JENNETTE SPARACO

2004 1:00 a.m.

FEBRUARY 10,

Registrar

0

State

29a. Certifier

29b. Signature and title of certifier

TARIQ MAHMOOD 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year)

FEB 1 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

104

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item#19bperINFG8282/27/04 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Month Year 1-10 am aw rence eb 2004 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner alt more VA MedicAL ( MALT MORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days X<sup>1</sup>XM 2□ F Director 216-28-9578 Usual Residence of Decedent 24 34 69 09 MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mantal Hygiene. mportant: If item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified 11 Yes 2 □ No Director NA Baltimore MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Be Completed by Funeral 21215 1027 Cathedral Street Apt U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1X Yes 2 □ No If Yes. Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Longshorman Decks na 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Smith Sr. Dorothy Hayes 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Way, 20 Mission Edna Mims-Sister Reisterstown, Md 21136 other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 injury Garrison Forest Vet. 2/17/04 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that oused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner buriel-transit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) for use es the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was en autopsy performed? 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA After this funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural s efter death. 1 Yes 2 No 2 Accident by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C completely filled the Hospital Medicai ( 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Dav. Yeer) ress of person who completed cause of death (Item 23e) (Type, Print)) 30. Neme and add Ď IDN. URLENE STREET.

State

Registrar

mlle

FEB 1 2 2004

31. Date filed (Month, Day, Year)

ren

32 Registrar's Signature

			70 TEX 114 GO2	9 3/22/04/4	partment of H Artificate of L	Jean	H	g. No.	0100
Physici /Medi		Decedent's Name (First, Middle, L  James	Last)	S	mith		2. Date of Deat Month 2 9	Day Y	'ear 6:10p
Examir		4a. Facility Name (If not institution, g Genesis Health				Location of Death		4c. County of	
Funeral Director		215-60-0571	Sex 7. Age 10 M 2□ F 5.	e (In yrs. last birthda) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-15-	Year)	9. Birthplece (State or Fore Country) Va.
tural, or items 23a or 28e-f show	_	Usuel Residence of Decedent  10a. State  10b. County		10c. City, Town or I	ocation				10d. Inside City Lin
or 28e-f	Irecto	Md. 10e. Street and Number	AV	F	Baltimore 10f. Zip Code		10	g. Citizen of Wh	1 X Yes 2 □ at Country?
er must b	Funeral Director	3005 Kenyon Ave.	12. Was Decedent E	Ever in U.S. 13	21213 Was Decedent of Hilf Yes, specify Cubar	spanic Origin? (Spon, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
ural', or l	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	Black
ene. than "na he Medic	Completed	15. Decedent's to (Specify only highest g  Elementary/Secondary (0-12)		+) (Giv	edent's Usual Occupa e kind of work done of DO NOT use retired,	furing most of worki	ing	6b. Kind of Busi	ness/Industry Callahan, Ir
d othe	To Be Co	9th grade 17. Father's Name (First, Middle, Las Junior	•	Mills	onstructio	18. Mother's Name Nadi	e (First, Middle, N	laiden Sumame)	
and and	-	19a. Informant's Name/Relationship	(Type, Print)	3005	ling Address (Street a				ate, Zip Code)
0		Carolyn Smith  20a. Method of Disposition  1 Burial 2 Cremation 3		20b. Place of Disc	ematory or other place		Date 2		ty or Town, Stete
Department Important: I any injury o once.		*4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		1	22. Name and Addres		Balti	more, Mo	1. 21202
ysician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that caused by one cause on each lin	the death. Do not en		g, such as cardiac o	or respiratory arre		Approximate Interval Between Onset and Deat
Medical kaminer		resulting in death)	Due to (or as a	consequence of):	may 10 C	eficienc	-11-01	MON	
am and rial-transit		Sequentially list conditions	b				)	)	
ysician and ie burial-trans	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):				)	
y the attending physician and ched for use as the burial-transit	edical	that initiated events	c	a consequence of):  a consequence of):  of pregnancy 2 Fetal death 3	□Ectopic pregnancy			23d. Date of Month	of delivery
gned by the attending se detached for use a	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	c	a consequence of):  a consequence of):  of pregnancy  2	□Ectopic pregnancy		23e. Did tob	23d. Date of Month	of delivery
as been signed by the attending 2 should be detached for use a	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	a consequence of):  a consequence of):  of pregnancy  2	□Ectopic pregnancy		23e. Did tob. 1  Ye: 24e. Was an autopsy perform	23d. Date of Month according to according a 2 No 3 2 4b. We price add?	of delivery Day Year
certificate has been signed by the attending rector, page 2 should be detached for use a	Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	c	a consequence of):  a consequence of):  of pregnancy 2   Fetal death 3 time of death 5	□Ectopic pregnancy □ Other (specify) underlying cause give	n in Part I.  26. Place of Death	23e. Did tob.  1  Yes  24e. Was an autopsy perform 1  Yes 2.	23d. Date of Month according to the second s	of delivery Day Year  ute to the cause of death Probably 4 Unknown re autopsy findings avail, ir to completion of cause th? I Yes 2 \( \) No
n. Affer this certificate has been signed by the attending tuneral director, page 2 should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	c	a consequence of):  a consequence of):  of pregnancy 2 Fetal death 3 time of death 5  it not resulting in the	□Ectopic pregnancy □ Other (specify) □ underlying cause give underlying cause give	n in Part I.  26. Place of Death r: Nursing Hor	23e. Did tob.  1  Yes  24e. Was an autopsy perform 1 Yes 2.	23d. Date of Month  acco use contributes 2 \( \text{No} \) 3    24b. We prode dea 1    acco 6 \( \text{Other} \)	of delivery Day Year  ute to the cause of death Probably 4 Unknore autopsy findings avail in to completion of cause th? Yes 2 No
n. After this certificate has been signed by the attending tuneral director, page 2 should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death	C. Due to (or as a d	a consequence of):  a consequence of):  of pregnancy 2	□Ectopic pregnancy □ Other (specify) □ underlying cause give ent 3□ DOA of 28c. Injury Work M 1□ Y	n in Part I.  26. Place of Death f: \( \frac{1}{2} \) Nursing Hor at 7 (es 2 \( \sum \) No	23e. Did tob: 1	23d. Date of Month  acco use contributes 2 \( \text{No} \) 3 \( Post of the rest and Number of the Number of	of delivery Day Year  ute to the cause of death Probably 4 Unknown of the cause of the cause of death To completion of cause the completion of cause the cause of
n. Atlar this cartificate has been signed by the attending tuneral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a d.  23c. If yes, outcome of the contribution of the contribution of the contribution on the contribution of the contribution on the contribution of the contribution on the contribution on the contribution of th	a consequence of):  a consequence of):  of pregnancy 2	DEctopic pregnancy Other (specify)  underlying cause give  ant 3 DOA of 28c. Injury Work M 1 Y treet, factory, office	n in Part I.  26. Place of Death  The Nursing Hore at the second of the	23e. Did tob: 1  Yes  24e. Was an autopsy perform 1  Yes 2  1  Check onl one me 5  Resider 28d. Describe how City or Town,	23d. Date of Month acco use contributed accounts account accou	of delivery Day Year  ute to the cause of death Probably 4 Unkn re autopsy findings avail to completion of cause th? Yes 2 No  (Specify)
this certificate has been signed by the attending al director, page 2 should be detached for use a	To Be Completed by Physiclan/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	C. Due to (or as a d.    23c. If yes, outcome of the pregnant at the pregnant	a consequence of):  a consequence of):  of pregnancy 2	DEctopic pregnancy Other (specify)  underlying cause give  ant 3 DOA of 28c. Injury Work M 1 Y treet, factory, office	n in Part I.  26. Place of Death  A Nursing Hor  at ? es 2 \( \sum No)  e, date and place, a inion, death occurre	23e. Did tob.  1  Yes  24e. Was an autopsy perform 1  Yes 2.  1  Check ont one me 5  Resider 28d. Describe how  28f. Location (Strr. City or Town, and due to the called at the time, dat	23d. Date of Month acco use contributes 2 No 3 24b. We price dea 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of delivery Day Year  ute to the cause of death Probably 4 Unknown re autopsy findings avail for to completion of cause th? Yes 2 No  (Specify)  or Rural Route Number.

		1 - For State Registrar	State of	f <b>M</b> arylan	d / Depa		t of H	ealth a	and M			nni.	04337
		1. Decedent's Name (First, Midd	lle, Last)							2. Date of De. Month	ath Day	V	3. Time of Death
	sician edical	Larnerine	Lucille S	Smith						Februa	ry 10	2004	4:15 A M
	mine	A. P Mr. Alexan // and in stitute.	on, give street and num	nber)		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death	
		Mariner Health	at North	Arunde1		Gle	n Bu	rnie			Ann	e Arun	del
Fune	ral	5. Social Security Number		7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Aug 2,	h V. Year)	9. Births MD	place (State or Foreign
Direct	or	216-14-7136	1□M 200F	80	Yrs.			110010		Aug 2,	1923	MD	
ъ.		Usual Residence of Decedent  10a. State 10b. Count		10a Cit	v. Town or Lo	anti							Od Jasida Cit. Linia
aryle hov					en Bur								0d. Inside City Limits 1 ☐ Yes 21 No
8e-1	1 3	MD Anne	Arundel	GI	en bur								
or 2	Superal Director	10e. Street and Number			0.0	10f. Zip						of What Cour	ntry?
eth w	2	114 Water Four		Unit l			1060					U.S.A.	
te de	2	11. Marital Status	Armed Fo		.S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Ori n, Mexicar	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.)	- 14.	Race · Americ Black, White,	
S off	1		If Yes, Giv	2/ No		1 ☐ Yes 2	No D	Specify:			Sp	ecify: wh	ite
be filed within 72 hours efter death with the Maryland lei Hygiene.  lei Hygiene.  oother then "neture!", or tteme 23e or 28e-f ehow ovent. The Margine Farmer of the notes that the confined marginer must be notified.	1 5		d Year or Do	ates:		dent's Usua		tion			16h Kind	of Business/In	
27 n 72	petelumo	(Specify only high	est grade completed)		(Give	kind of wor DO NOT us	k done d	lunna mos	t of worki	ng	Top. King (	DUSINESS/III	dustry
t be with it		Elementary/Secondary (0-12)	College (1	-4or 5+)	Admin						Hea1	thcare	
Hygi at	١		, Last)					18. Mothe	er's Name	(First, Middle,			
d be on the control	a							Emil	1 v K 1	ausmey	or		
M Me Mark	F	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	na Address	(Street a			I Route Numbe		wn. State. Zin	Code)
d 2 s d 2 s the man		Mrs. Beverly D		ghter		_				idena, l			,
		20a. Method of Disposition	,		Place of Dispo					ate		ion - City or To	own, State
	-	1 XBurial 2 Cremation		State	emetery, crei n Have				Feb 1 2004	.2	01	Diimeda	MD
Description of the properties		*4 □Donation 5 ☑ Other ( 21. Signature of Juneral Service	7	GTE						1 .		Burnie	
partificate, Marylatin ATA 13-0030 permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Heelih and Mentel Hyglene. Important: If item 27 is marked other then "neturel; or iteme 23e or 28e-f show any injury or other treumstite event. Its Medical Example must be notified as	ouc	21. 30.	000	mala	3/9 1	Seco	nd A	venue	Sin Sin	gleton V., Gle	runer n Burn	al Hom ie, MD	e P.A. 21061
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that o	aused the deat	-//								Approximate
Stooy  ete be executed  mysicien end  mysicien end  hysicien end  he buriel-transit	er		<b>1</b>	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a co									
the deeth certific y the attending ploched for use es.	Dhive Infort Man	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 □ No 9 □ Unknown	1 ☐ Live b	come of pregna irth 2 ☐ Feta ant at time of d	death 3	□Ectopic pre					23d	. Date of delive	ery Day Year
Ords, Frequires thet een signed be dete	2	Part II. Other significant condit	tions contributing to de	eath but not res	ulting in the u	nderlying ca	ause give	n in Part I	•	23e. Did to	obacco use	contribute to the	ne cause of death?
STOS Squires en sign	3	omenha,	Mriot	Grello	lon					10	res 2190N	lo 3 Prob	pably 4 Unknown
aw req	patalogue		V							24a. Was		4b. Were auto	psy findings available mpletion of cause of
The law	.   8										rmed?	death?	2 <b>X</b> 0No
		25. Was case referred to medic	al					26. Place	of Death	(Check only o			
90 (0 -	9	1 Tes 2 No	Hospital: 1 🔲	npatient 2	ER/Outpaties	nt 3 🗆 DO	A Othe	01: 4 <b>⊠</b> Nu	ırsing Hor	ne 5□Resid	ience 6	Other (Specif	v)
			28a. Date	of Injury th, Day Year)	28b. Time o	f 21	8c. Injury Work			28d. Describe I			
Attending r deeth.	-	1 Alatural 5 Pend 2 Accident inves	tigation	,,	,,	M		res 2□	No				
Attending at deeth.		3 Suicide 6 Couk	mined 289. Place	of Injury - At h		reet, factory	, office		2	28f. Location (S City or Tox		umber or Rura	I Route Number,
			0000	ing, etc. (c)cool	<i>y</i> /					O., 0	, 0.0.0)		
To the Hospital or Attent within 24 hours efter deelt to the Funeral Director:	100		ing Physician: To the Il Examiner: On the band man	best of my kno asis of examina ner stated.	owledge, deat tion and/or in	h occurred a vestigation,	at the tim , in my op	e, date an pinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as s ice, and due to	tated. the cause(s)
To the Within To the		29b. Signature and title of certif	ier			29c	. License	number			29d. Date si	igned (Month,	Day, Year)
1		D11,	MO			1	38	958	2		2/1	0/04	•
		30. Name and address of perso		e of death (Iter	n 23a) (Type,	Print)		1			1	-/	-
		Da Pet C	rosch Ci	My 11	4/3 h	nolo	1,1	Kor	d.	#106	Ochen	Tou M	021113
-	State	31. Date filed (Month, Day, Year	32. A	egistar's Signa	ature	6	W.						
Reg	jistra	FEB	1 2 2004	Phy.	and the same	Ares	11						

Physician /Medical	1.	Decedent's Name (First, Middle, L.	Josep	h Swar	rtz			F	ebruar	Day Year	3. Time of Death
Examiner	4a	. Facility Name (If not institution, gi Union Memorial	ve street and number Hospital	)		4b. City, Town Baltiп	nore			N/A	ith <sup>1</sup>
uneral rector		214-12-4567	Sex 7.A XIX M 2□F	ge (In yrs. Ias 94	Yrs.	If Under 1 Ye Months Day		Min. De	Date of Birth (Month, Day, Ye C 1, 19	9. Bir 09 Scr	thplace (State or Foreign ountry) anton, PA
f show led at	-	Sual Residence of Decedent  Da. State 10b. County  MD	N/A		Town or Lo						10d. Inside City Limits 1 XX es 2 □ No
in teme 23a or 28a-1 s. Liner must be notified. Funeral Director	10	De. Street and Number  3838- Roland Av 3939	e. Apt.	604		10f. Zip Code 212			10g.	Citizen of What C	ountry?
0 5	1	1. Marital Status  1. Never Married 2. Married  XX Widowed 4. Divorced	12. Was Deceden Armed Forces 1 XX es 2 □ If Yes, Give Year or Dates	?  No 194	5	Was Decedent of If Yes, specify C			y Yes or No- an, etc.)	14. Race - Am Black, Whi Specify:	
traumatic event, the Medical Exiteration for the Traumatic event, the Medical Exiteration for the Medical Exiterat		15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 5th	Education rade completed) College (1-4or	5+)	16a Dece (Give life Welc	dent's Usual Ockind of work do PO NOT use ref	cupation ne during mo. ired)	st of working	161	Beth Ste	
atic event, tr	1	7. Father's Name (First, Middle, Las	Georg	e Swar			E	va Ado	First, Middle, Mar omaites		
or traumatic ev	1	9a. Informant's Name/Relationship Robert Nicholson	(Type, Print)						Route <i>Number, C</i> Monkton	ity or Town, State, , MD 211	
y injury or other trauce.	2	0a. Method of Disposition  1XXBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	□Removal from Stat	e Dru	ce of Disponence netery, cre lid Ri	osition (Name of matory or other) dge Cem	olace) etery	2/16/		c. Location - City o ikesville	
any inju	2	21. Signature of Funery Service Lic	anseg -	to	B <sub>1</sub> <sup>2</sup>	2. Name and Ad Irgee-He 31 Fall	nss-Se s Road	itz Fu Balt	neral H	ome <sub>11</sub> Inc.	
to use as the burial-transit  tor use as the burial-transit  and positive transit  and p		23a. Part1. Enter the disease, or co- shock, or heart failure. List on mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	a. Due to (or a b. Due to (or a c.	line.	s He ance of):	art F		s cardiac or r	aspiratory arrest		Approximate Interval Bate Interval Bate Interval Bate Onset and Death 7 years
be detached for use as to be detached for use as to be detached for use as to detach as the detach a		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal of dea	death 31	⊒Ectopic pregna ⊒ Other <i>(specif</i> y				23d. Date of d Month	elivery Day Year
		Part II. Dther significant conditions	contributing to death	but not resul	ting in the	underlying cause	given in Part	l.			to the cause of death?  Probably 4 Junknown
page 2 should	-								24a. Was an autopsy performe	24b. Were a prior to death?	autopsy findings available completion of cause of es 2 No
certificate rector, pag		25. Was case referred to medical examiner?	Hospital:	275	:D/O: 1==1	-1 2C DOA	Othor		Check only one)	ce 6 □Other (Sp	ancifu)
To the Funeral Director: After this cartific completely filled in by the funeral director.  Medical Certification: To Be (	10	1 ☐ Yes 2 No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Ir (Month, L		28b. Time Injury		Injury at Work? 1 Yes 2	28	d. Describe how		ecity)
el Director: Alter tied in by the funera		3 Suicide 6 Could no determine	288. Place 01	Injury - At hor etc. (Specify)	ne, farm, s	treet, factory, off	ice	28	f. Location (Stre City or Town,		Rural Route Number,
To the Funeral Directomplately filled in by Medical Certif		29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the be aminer: On the basis and manner	of examinati	vledge, dea on and/or i	th occurred at the	ne time, date a my opinion, de	and place, an eath occurred	at the time, date	and place, and di	ue to the cause(s)
com		29b. Signature and title of certifier	Elm J	M.	1.		-2438			ebruar chruar	
		30. Name and address of person wi	o completed cause o	f death (Item	23a) (Type	, Print)	Rich	and E.	Cooks	~ , M.D.	27

DHMH 17 Rev 1/2001

Registrar

FEB 1 2 2004

Spagnos 1

		1 - For State Registrar	State of Maryland /		artment of H		ind M		ene 20 (	04340
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Cecil R. Smith,	Jr					2. Date of Death Month Februar	y <sup>Da</sup> έ, 2ở0	3. Time of Death 3. 44 AMM
Exami		4a. Fecility Name (If not institution, give st. Broadmead	reet and number)			ysvil	1e			timore
Funeral Director		321-30-2781	7. Age (In yrs. last bi	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, ) May 31,	9. 1924 C	Birthplace (State or Foreign Country) olorado
Maryland f show	tor	Usual Residence of Decedent  10a State 10b County Baltimore	10c. City, Tov		cation ysville					10d. Inside City Limits 1 ☐ Yes 2 No
3s or 28s	Funeral Director	10e. Street and Number 13801 York Road E	3		10f. Zip Code 2103	0		10	g. Citizen of Wha	t Country?
rs after death	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H I Yes, specify Cuba I □ Yes 2∏ No	ispanic Orig an, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		American Indian, White, etc. White
is 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other treumatic event, the Medical Examinatinative inclining at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12	ation 16a	(Give	lent's Usual Occup kind of work done OO NOT use retired chemi	during most 1)	of workin		6b. Kind of Busine	ess/Industry unk
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event. The Magnesia.	To Be C	17. Father's Name (First, Middle, Last)  Cecil Randolph St				Elsi	ie My			
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Typ. Donna S. Smith/spo	ouse	13	g Address (Street 801 York		E3 C	ockeysvi	ille, MD	21030
Pages 1 ment of H ant: If Ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☒ Donation 5 ☐ Other (Specify)	moval from State	ery, cren	sition (Name of natory or other plac				Oc. Location - City	
permit Depart Import		21. Signatur of Tynera Sarvice Licenser	Collect-	Dè	illimore,	MD .	2120.	<u> </u>		e Street
Physician /Medical Examiner		23a. Pakt. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.  Due to (or as a consequence	AR.	or the mode of dying DEM	,			it,	Approximate Interval Between Onset and Death
alth certificate be executed attending physician and for use as the burial-transit	Ilcal Examiner	f any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
The law requires that the death certificate are been signed by the attending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)	- Can			23d. Date of Month	delivery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions cont	ributing to death but not resulting	in the ur	nderlying cause giv	en in Part I.				te to the cause of death?  Probably 4 □Unknown
	Completed							24a. Was an autopsy performe 1 Yes 2	ed?/ prior	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manne of Death  1  Autural 5 Pending 2  Accident investigation		utpatien Time of Injury	t 3 DOA Oth	er: 4 Nu	rsing Hon	(Check only one) ne 5 Residen 8d. Describe how	ce 6 Other (5	Specify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, str	eet, factory, office		2	8f. Location (Stre City or Town,		r Rural Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Examinations)	cian: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death nd/or inv	estigation, in my o	pinion, deat	d place, a	ed at the time, dat	e and place, and	due to the cause(s)
With To To com	Σ	29b. Signature and title of certifier	Carroll	W.	29c. Licens	38	390	290	d. Date signed (M	2004
		30. Name and address of person who con	RROLL,M.	(Туре,	Print)   3801	Yo	rk	Rd.	Cocke	ysville, MD
St Regis	ate trar	31. Date filed (Month, Day, Year)	32 Registrar's Signature	20	seles	Ť			C	/

	1 = For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of He of D	alth and eath	d Mental I	lygien Reg. N	201	04 01	34
Dhominian	1. Decedent's Name (First, Mid	dle, Last)						2. Date of	Death Da	ıy Y	3. Time	of Death
Physician /Medical	WILLIAM						COTT	FEBRUA	24 4	20	04 1213	PM
Examiner			number)		,		ocation of D	eath	40	c. County of	Death	
	JOHNS HOPKINS  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	MOR Year	If Under 24 F	Hrs. 8. Date of	Birth	9	Birthplace (State	or Foreign
Funeral Director	218-28-0199	1 <u>M</u> M 2□ F		Yrs.	Months			in. (Month	Day, Year		Birthplace (State Country) arvland	or roroign
	Usual Residence of Decedent							, 000	10, 1.	752 11		
and Mental Hygiene.  la marked other than "natural", or Itema 23a or 28a-f ahow aumatic avant, the Medical Examinar munt be notified at  To Be Completed by Funeral Director	10a. State 10b. Coun	У		ity. Town or Lo Baltimo							10d. Inside	
Department of Health and Mental Hygiene. Important: If Item 27 ta marked other than "natural", or Itema 23a or 28a-f ahow any injury or other traumatic avent, the Medical Expression must be notified at ance.  To Be Completed by Funeral Director	TID .			Daltino	ore -						1£JYe	s 2 No
or 26	10e. Street and Number	1 // 0			10f. Zip	Code	0100		10g. C	itizen of Wha	•	
23a	925 North Broa			10 100			21205		1	US		
r Hema 23a or 28a-fa Tracrum be natified Funeral Director	11. Marital Status 1 Never Ma <i>r</i> ied 2  Ma	Armed	ecedent Ever in l Forces? s 2 ☐ No	unk 13.	was Decede	fy Cuban,	Mexican, Pu	(Specify Yes or Jerto Rican, etc.	No-		American Indian, White, etc.	
by F		If Yes		dire	1 ☐ Yes 2	⊠ No	Specify:			Specify:	black	
rate rate red	15. Decede	nt's Education		16a. Dece	dent's Usual	Occupati	on	uı	1k 16b. I	Kind of Busin	ess/Industry	unk
nt, the Wedical E	(Specify only high Elementary/Secondary (0-12)	est grade complete College	d) (1-4or 5+)	(Give	kind of worl DO NOT use	e retired)	ring most of	working				G1110
	unk	unk	,									
d oth	17. Fathers Name (First, Middle 1	, Last)				unk 1		Name (First, Mic		n Sumame)		
To To	2							lyn Sudl				
raum	19a. Informant's Name/Relation Johns Hopkin		1		•			Rumal Route Nu 1timore			te, Zip Code)	
her	20a. Method of Disposition			Place of Dispo			т Ба	Date	-		y or Town, State	
0	1 ☐ Burial 2 ☐ Cremation	3 Removal fro	m State	cemetery, crer	natory or oti	her place)		54.0	200. 6	.002(1011 - 010	y or rown, state	
njury	* 4 □ Donation - 5 ☒ Other		tate	20	2. Name and	Address	of Escility					_
eny	21. Signuture of Funer I Service	S. Wade,	Directo	r / St	ate A	nator	my Boa	rd 655 1	W. Ba	ltimor	e Street	:
	23a. Part 1. Enter the disease,	or complications that	it caused the dea						ry arrest,		Approxim	ate
	shock, or heart failure. Li										Interval B Onset and	
cian Iical	disease or condition resulting in death)	a.	ox(A to (or as a conse	nuence of):							TWO DA	2.2
iner			ONIC ORS		PUL	MONA	124 O	ISEASE			FRN 46	Aa
- T	Sequentially list conditions, if any, leading to immediate cause. Error underlying	U.	to (or as a conse									
rial-transit	Cause (Disease or injury that initiated events	С.										
Ex	resulting in death) Last	Due	to (or as a conse	quence of):								
s the burial-transit		d.					_					
e as		220 16 1100		247		- P. 197-2	1 - 1 - 5 - 5A		70-1		- 196/10.5	
detached for use as	23b. Was decedent pregnant in the past 12 months?	1□Liv	outcome of pregree birth 2 Fet	al death 3	Ectopic pre					23d. Date o Month	t delivery Day	Year
Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Un	gnant at time of known	ueam 5L	Other (spe	y)						
deta Ph	Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying ca	use given	in Part I.	23e. D	id tobacco	use contribu	te to the cause of	death?
o po		TERM DISE	ASÉ					1	☐ Yes 2	!□No 3	Probably 4	]Unknown
should be det	LANGUA DENCLOSA								√as an	24b. Wer	e autopsy finding	s available
16 2	HYPER TENSION							– a	utopsy erformed?	prio dea	r to completion of th?	cause of
or, pa			s E				26 Place of	1 ☐ Ye Death (Check or	s 2 N	1 1 1	Yes 2 No	
Tect Ce	examiner?	Hospital:	Inpatient 2	] ER/Outpatier	nt 3 🗆 DO			g Home 5□F	-	6 □Other /	Specify)	
S - I -		28a. Da	te of Injury onth, Day Year)	28b. Time of		c. Injury a Work?	ıt			ry occurred	ороонуу	
the fun	1 Natural 5 Pend 2 Accident inves	ling (M tigation	onni, Day rear	Injury	м		s 2 🗆 No					
ed in by the funera	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 286. Pla	ice of Injury - At t	nome, farm, str	eet, factory,	office			n (Street a Town, Stat		or Rural Route Nu	mber,
i be											and the same of	
pletely filled in by the funera	29a. Certifier 1 Certify (Check only 2 Medic	ring Physician: To al Examiner: On the										(s)
To the Complete		and m	anner stated.									
100	29b. Signature and title of certification	)				License !					fonth, Day, Year)	
	8	5	MD			ES - 0	00		FERM	MARY	4,2004	
	30. Name and address of person		iuse of death (Ite			6.00	MARAM	ulai Er iss	cet s	As er s s s s	6	
State	31. Date filed (Month, Day, Yea		Begistrar's Sign	ature		9 00	hor: H	WOLFE STR	cei B	MUSIMON	E MARYLA	עאי
State Registrar		- V	8	N Par	ack)							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

16362 Certificate of Death AMEND ITEM #8 PER FH G828 2/17/04 JH 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Alice Evelyn Schoppert February 9, 2004 4:25 p.m. /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Riverview Care Center Essex Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 3\_29-1913. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number Funeral Days Months 1 □ M 250 NF Yrs 90 215-01-9603 March 3,1913 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Items 23e or 28e-f should be notified at 1, Yes 2 □ No Maryland Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Newcomb Way 21205 U.S.A. Funeral Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2☐No f Yes, Give 1 ☐ Never Married 2 ☐ Married th and Mental Hygiene. 7 is marked other then "netural", or I treumatic event, the Medical Exami Specify: White 1 ☐ Yes 20 No Specify: 3altimore, Maryland 21215-0020 ۾ ₩Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Riveter Aero-Space 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Wheeley Lillian Grubb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health of Hea Richard Schoppert, Sr. (Son) 908 Arncliffe Road, Essex, Maryland 21221 other 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If Ite eny injury or ot once. 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 2/11/2004 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Hyperten Rive ather-orderate Cardio Vascular diserse **Physician** Immediate Cause (Final disease or condition resulting in death) un Known /Medical Examiner Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical | Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1) ementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ ₩ known signed d be del 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? certificate has been si irector, page 2 should 21 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide 5 filled in I 24 hours To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check only one) 29c. License number
D-38 754 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier Mae-MD 02-11-2004 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTERN BLUD, BALTIMORE, MD-21221 WASERM. MALIKA 31. Date filed (Month, Day, Year) 32. Registrar's Signature 22.2 works Registrar 2004

**DHMH 16 Rev 6/95** 

			For State Registrar	State of Marylar	nd / Depa	artment of F	lealth and i	Mental Hygi	ene g. No. 200	+ 04343
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Helen F      4a. Facility Name (If not institution, give submitted to Memorial Hos	R. Talbott		4b. City, Town, o	r Location of Death	2. Date of Death	Day Year	3. Time of Death  2: 30 p M
	Funeral Director		5. Social Security Number 6. Security Number 236-26-1844	7. Age (In yrs.	last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 24		thplace (State or Foreign ountry) est Virginia
	e Maryland	Director	10a. State 10b. County	10c. Ci	ty, Town or Lo Bal	cation timore				10d. Inside City Limits 11€ Yes 2 □ No
	with the or 21	Dire	10e. Street and Number 3939 Roland Av	ronuo Ant 80	18	10f. Zip Code	21211	10	og. Citizen of What Co US	
36	within 72 hours after death with the Maryland ene. than "natural", or flems 23a or 28a-f show the Modical Extroiter mast be notified at	by Funerai		12. Was Decedent Ever in U Armed Forces? 1 □ Yes X No If Yes, Give Year or Dates:	I.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※※ No	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
21215-0036	thin 72 hours e. an "naturel", Medicel Exte	Completed I	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	6b. Kind of Business	/Industry
land 21	be filed tal Hygi d other event.	To Be Con	11th 17. Father's Name (First, Middle, Last) Richard Ramage		Te	elephone (	18. Mother's Nar	ne (First, Middle, M		etail Store
, Maryland	12 sh ar	-	19a. Informant's Name/Relationship (Ty Nancy E. Waddell	(Niece)	3432	. Keswick		Baltimor	City or Town, State, . e, Marylan	
Baltimore,	S = = 0		20a. Method of Disposition  1X□XBurial 2 □ Cremation 3 □ F  14 □ Donation 5 □ Other (Specify)		ce View		l Park 2/	13/2004		e, Maryland
Balt	permit. Page Department of Important: If any injury or ance.		21. Signstand Juneral Service Volume	asely	2: E	2. Name and Addre Surgee-Her 8631 Falls	ss of Facility ISS—Seitz S Road I	Funeral Baltimore	Home, Inc , Maryland	21211
	Physician /Medical Examiner		23a. Part 1. Enter the disease, of complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause on each line.  a	on or en	ter the mode of dylin	ng, such as cardia	or respiratory arre	Discol	Approximate Interval Between Onset and Death
,092	eath certificate be executed attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
Δ.	quires that in signed b uld be deta	ed by Pl	Part If. Other significant conditions con	ntributing to death but not res	sulting in the u	inderlying cause giv	ren in Part I.	1	acco use contribute to	o the cause of death?
al Records,	ysician: The law requir is certificate has been si director, page 2 should	Complet						24a. Was ar autopsy perform 1 Yes 2	y prior to	utopsy findings available completion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	I EB/Outpation	ot all DOA Oth	or	ath (Check only one	nce 6 ☐Other (Spe	2016.1
Division of	this al d	Certification: To	27. Manner of Death  1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. ate of fnjury (Month, Day Year)	28b. Time o Injury	of 28c. Injur Wor M 1	y at	28d. Describe ho	w injury occurred	
Divi	To the Hospital or Attending F wit in 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	28e. Pface of Injury - At h building, etc. (Speci	(fy)			City or Town		
	To the Hospital or within 24 hours after To the Funeral Dirticological or pletely filled in It	ledical	(Check only 2 Medical Exami	sician: To the best of my kni ner: On the basis of examini and manner stated.	owledge, deat ation and/or in	ivestigation, in my o	pinion, death occi	irred at the time, da	ite and place, and due	e to the cause(s)
)	T with the contract of the con	2	29b. Signature and title of certifier	of D	D	DOC	5555	68 F	ed. Date signed (Moni EGFUQV.	
	D	y	30. Name and address of person who co	earn te	23a) (Type,	Print) IN	Inive	rsity	Parkua	y 09, 2004 Baltimon
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature V	Brank .		. /		//

			For State		aryland / D	epartment of h	Health and I			J. 01.21.1.
			Registrar			Certificate of	Death		eg. No.	4 04044
	Physicia /Medica			E. Thomps	on			2. Date of Dea Month	n 9,200	4 1992b W
	Examine	r	4a. Facility Name (If not institution, give	1 1	lacation!		or Location of Death	ו	4c. County of D	eeth
			Monjoine Ge 5. Social Security Number 6. S.	neral 1	e (In yrs. last birti	bacti		8. Date of Birth	N/A	Sighala - (Otata - Camina
	Funeral Director			□M 2 <b>X</b> F		rs. Months Days	Hours Min.	August 2	Year)	Birthplace (State or Foreign Country) aryland
	land	ł	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	he Mary 28a-f sh	Director	Maryland N/A	1	Ва	ltimore				XX Yes 2 □ No
	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland entment of Heatth and Mental Hygiene. crient: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, if a Modical Exeminar must be rotilied at a	a Dir	10e. Street and Number 2628 Hampden Avenu	ıe		10f. Zip Code	21211	1	0g. Citizen of What U	SA
	ams ams	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian,
<b>∑</b> 28	urs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ※【※ Divorced	1 ☐ Yes 2√2√1 If Yes, Give Year or Dates:	No.	1 ☐ Yes XXX No			Specify:	white
77 CM	natur	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wor	king	16b. Kind of Busine	ss/Industry
$\subseteq \frac{5}{2}$	within ane. than	E E	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homemaker	-		T- 0 1	T
D 2	Hygie ther ther		17. Father's Name (First, Middle, Last)			Homemaker		ne (First, Middle, I	In Own I	nome
and	d be interested to the control of th	Be	Elias E. Moon				Marga	· _	White	
Son jaryland	2 should be filled within and Mental Hygiene. is marked other than aumatic event, Ira M	0	19a. Informant's Name/Relationship (7		19b.	Mailing Address (Street				Zin Code)
SE	and 2 seatth arm 27 is		Charles Thompson,	• • • • • • • • • • • • • • • • • • • •	1	28 Hampden			e, Marylaı	
o Z	s 1 and 27 tem 27 other tr	- 1-	20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla			20c. Location - City	
Baltimore,	permit. Pages Department of i Importent: if its any njury or o		X ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify			hedral Ceme		13/04	Baltimore	e, Maryland
alti	permit. Deportmine importe any injuited once		21. Signature of Funeral Service Vices	500)		22 Name and Addre	see of Eacility			
Œ	Deporting Suny of Suny		Jeans Il	argenter	-	Burgee-Hen  3631 Falls	ss-Seitz Road	Funeral Baltimor	Home, Inc	and 21211
- 8			23a. Fan1. Enter the contact shock, or heart fall vie. List only	olic ite ns that caused	the death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition	Sentic	Shoc	k				Onset and Death
	/Medical		resulting in death)	Due lo (or as	a consequence o	1				
	Examiner		Sequentially list conditions.	, Intar	ctec	Powel				
15	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence o		^			
V	te be executed ysician and te burial-transit	хап	that initiated events resulting in death) Last	c. HTY I CC	a consequence of	rillatio	11			
760,	be ey	Cal		200 10 (0) 83 6	a consequence o	1).				
387	phys s the			d						
Box 68	eath certificate attending phys	VMe	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of	dolinan.
	0 0 0	by Physician/Medi	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	<i>y</i>		23d. Date of o	Day Year
P.0	d by t	r S	9 ☐ Unknown  Part II. Other significent conditions co	antalbuting to don't bu			E. S. B. L.	an- Didu-		
Division of Vital Records, P.O	uires ti n signe Id be c	d by	Pate II. Other significant conditions of	Antinouting to death bo	at not resulting in	ine underlying cause giv	en in Parti.			to the cause of death?  Probably 4 Unknown
Ō	w req	Completed						24a. Was ar	24h Were	autopsy findings available
Re	he la e has age 2	Ē						autops: perforn	y prior t death	o completion of cause of ?
ta	iffication, per	a l	25. Was case referred to medical				36 Place of Doc	1 ☐ Yes 2 th Check on one		es 2 No
5	s cert	0	evaminer?	Hospital: 1 Inpatier	int 2□ER/Out	patient 3 DOA Oth			nce 6 Other (S	necify)
0	g Ph er thi		27. Manner of Death	28a. Date of Injur (Month, Day		me of 28c. Injur		28d. Describe ho		300.197
Ö	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		, 10a1) III		Yes 2 □No			
ivis	er de recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farr	m, street, factory, office		28f. Location (Str City or Town		Rural Route Number,
	rs aft									
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysicien: To the best of liner: On the basis of and manner sta	examination and	death occurred at the tir for investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	orthin To the Somple	ğ.	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
			1 (NO)			89F	508		2.9.0	4
	1		30. Name and address of person who d	ompleted cause of de	eath (Item 23a) (T	ype, Print)				1 1
	7		Catherine Lu	-bwame	and	D 40 1	ranjla	nd Ge	neral t	tospital
	State Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Al a	0			

			For State	State of Maryland	Department of Health and Certificate of Death	Mental Hygier	1e 2001.	01.31.5
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. f	10.6004	3. Time of Death
	Physici /Medic		BERNICE	MARIE VA	RANO	Feb. 8	2004	5:00A.M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat		4c. County of Death	20001
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign ntry)
•	Director		1 10 at a colle	M 2/0 F 76	Yrs. Months Days Hours Min.	10-7-3	31 Penr	sylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits
	e Mary	ctor	MD BALTI	nole	PERRY HALL			1 ☐ Yes 2 X No
	death with the Maryland rms 23a or 28a-f show Linual be nutiting at	Funeral Director	10e. Street and Number	C. ct Tr	101./Zip Code	10g. (	Citizen of What Cou	ntry?
	death ms 23	eral	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No-	14. Race - Ameri	
36	or ite	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1 Yes 2 No Specify:	o Rican, etc.)	Black, White,	etc.
5-0036	72 hours after "natural; or ite		3 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	6a. Decedent's Usual Occupation	16b.	Kind of Business/Ir	ndustry
		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo. life. DO NOT use retired)	rking		, 1
12121	iled will have the there the	Co	17. Father's Name (First, Middle, Last)		18 Mother's Nac	ne (First, Middle, Maid	DRSING	Home
Maryland	nit. Pages 1 and 2 should be filed within ortament of Health and Mental Hygiene. ortant: If item 27 is marked other than injury or other traumatic event, the Me.	To Be	FRNACK HOL	GASH	PSRTA	+A (1)AS	HEINIS	PSKI
lary	2 shou and M is mar aumat		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Address (Street and Number or Ru	ural Route Number, City	y or Town, State, Zij	o Code)
	of Health of Health item 27		20a. Method of Disposition	20b. Place	and Disposition (Name of	Date 200	Location - City or T	20()
Baltimore,	ages ant of h at: If ite y or of		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	etery, crematory or other place)	n 11 ml =	menior	14
altir	permit. Pages Department of Important: If i any injury or once.	Ì	21. Signature of Funeral Service License	Duan		HIMORE		
8	88 3 2 8		& Kimberly G	repoting	FUANS FUNERALC	HAPPEL ROT		RORD.
			23a. Part1. Enter the disea, or complishock, or hear failur. List only on Immediate Cause (Final	e cause on each line.	Oo not enter the mode of dying, such as cardial			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen		CINDMA		hive years
8	Examiner		Securementally list coordinates	U.S				
	ed sit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):			
ς,	be executed sician and burial-transit	Examln	that initiated events cresulting in death) Last	Due to (or as a consequen	ce of):			
8760	ate be ex thysician the buria	dlcal	d					
9	leath certifica attending ph I for use as th	/Med	IF FEMALE:	3c. If yes, outcome of pregnancy				
Box	death certificate e attending phys d for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live birth 2 ☐ Fetel de 4 ☐ Pregnant at time of death	ath 3 ☐ Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
P.O.	the ache	hys	9 Unknown	9□ Unknown				
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resultin	ig in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to t 2 □ No 3 □ Prot	he cause of death?
COL	2 0 70	letec				24a. Was an		opsy findings available
Re	e la has	Completed				autopsy perform≱d? 1 ☐ Yes 2 🗶 N	prior to co	impletion of cause of 2□ No
/ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	itali		ath (Check only one)		
of	S	7	1 ☐ Yes 2 ☑ No ☐	1		lome 5 X Residence 28d. Describe how in		(y)
<u>o</u>	Attending I ir death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Time of 28c. Injury at Work?  M 1 Yes 2 No			
Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street City or Town, Sta		al Route Number,
	hours a uneral D	al Ce	29a. Certifier 1 Certifying Phys	ician: To the best of my knowle	dge, death occurred at the time, date and place	and due to the cause	(s) and manner as s	stated
\$	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examir one)	er: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occu	irred at the time, date a	nd place, and due to	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	W . M	29c. License number	29d. [	Date signed (Month,	
	di	ļ	30. Name and address of person who co	mpleted pause of death (Item 23	la) (Type, Print)	13	banany	10)2009
_	•		Manshell A. L.	enine 656	of North Charle	es Ba	Himohe	MD 21204
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	brock &		<del></del>	
	riegisii	au	FFR 1.5 COO	4 June 15 July 15.	- FOLINGS /			

State of Maryland / Department of Health and Mental Hygiene

							(	Cert	ificat	e of	Death			Reg. No.	UU4	} U	4346
B	Dhysisi		1. Decedent's Name	(First, Middle, i	ast)								2. Date of D	Dav	Year		me of Death
	Physici /Medic		LUCILLE	BROOKS I									FEB. 6	200	4	11:4	40 A.M.
	Examin	er	4a. Facility Name (If										ocation of Dea	th 4c. Co	ounty of De	ath	
	Funeral		RAVENWOOD  5. Social Security Nu	umber 6	Sex	7. Age (In yr:		luay)	If Under Months		If Under Hours		8. Date of Bi (Month, D	rth ay, Year)	9. B	irthplace (S	State or Foreign
委	Director		230-26-806 Usual Residence of I			7	'8 Y	rs.					DEC. 26,	1925		RGINIA	
	land w			10b. County		10c. C	City, Town	or Loca	ation							10d. Ins	ide City Limits
	Mary F sh	tor	MARYLAND			BAL	TIMORE	$\overline{z}$								1 🖳	Yes 2□No
	th the	Director	10e. Street and Num	nber					10f. Zip	Code		_		10g. Citizer	of What C	Country?	
	23a c		4615 PARK	HEIGHTS A	AVE				212	215				$U_{\bullet}S_{\bullet}A_{\bullet}$			
	er dez	Funeral	11. Marital Status		Armed F		U,S.	13. Wa	as Daced Yes, spec	dent of I cify Cub	Hispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0- 14.	Race - Am Black, Wh		an,
2	be filed within 72 hours after death with the Maryland tal Hyglene. I all Hyglene. I all Hyglene. I all Hyglene. event, The Medical Examiner must be notified at	by F	1 ☐ Never Marrie 3 ☑ Widowed 4		1 □ Yes If Yes, G Year or I	ive		1 0	□ Yas	2 No	Specify:			Sp	ecify: $BL^{p}$	ACK	
700-617	2 hou		(0	15. Decedent's	Educetion		16a. [	Decede	nt's Usua	al Occu	pation	4 = 4=	· to-	16b. Kind	of Busines	s/Industry	
7	thin 7 e. "n Med	Completed	Elementary/Secon		rade completed; College (	1-4or 5+)				se retire	pation during mos nd)	I OF WORK	urg				
7	led will		5	F1 4 8 8 1 1 11 - 1 -	-43		CRAE	3 PIC	KER		40.14-45		- /Final Adiabat	SEAFO			
מם	l be fi	Be	17. Father's Name (F		St)								e (First, Middle H BROOKS		mame)		
Š	should id Me mark matic	To	19a. Informant's Nar		(Type, Print)		19b.	Mailing	Address	(Stree			al Route Numi		own. State.	Zip Code)	
Z	nd 2 stith ar atth ar 27 is		HATTIE BRO										LTIMORE,				
<u>5</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If the XT is marked at the nime insture!; or items 23a or 28e-f show important: If the XT is marked at the nime instruce. In the XT is marked at the Information of the Itemmetic event, the Medical Examiner must be notified at once.		20a. Method of Dispo				Place of I	Disposit	tion (Nar	ne of ther pla	ice)	I	Date	20c. Local	tion - City o	or Town, Sta	ate
allino	Page nent ant: If ury o		1 Donation		☐Removal from cify)	BU	ELAH E					2,	/14/2004	LIVELY,	VIRGI	NIA	
	permit. Departi Importi eny Inf		21. Signature of Fun	neral Service Lic	ensee	/ /.		22.1	Nama an	d Addre	ess of Facili	ty					
_	20 E 9 9		P1 1	70	, W	uM	M	BER	RY O.	WAL	DY FUNE	ERAL I	HOME P. (	BOX 3	805 LAN	CASTER	VA 2250
			23a. Part1. Enter the shock, or heart	e disease, or co t failure. List on	mplications that ly one cause on	caused the de each line.	ath. Do no	ot enter	the mod	le of dyi	ng, such as	cardiac	or respiratory	arrest,		Interv	ximate el Between and Death
3.0	Physician /Medical		Immediate Cause /F	Final	N 13			1			4		1	ß.			and Death
	Examiner		Immediate Cause (F disease or condition resulting in death)	ומי	aHINE	2050	cles	01	ic	Co	rdic	y c	ascode	v di	S CESC	y	Car
		Jer			4.1	<b>D</b> 00 10	1	onsoque	onice on.							1	20-6
	ertificate be executed ling physician end se es the buriel-trensit	Examiner	Sequentially list con	nditions.	b. 1	Due to	ten (oras a co									90	913
Š,	e exe		Sequentially list con if any, leading to immoduse. Enter Under Cause (Disease or in that in the control of the	mediate rlying		inde	OT	a	re8	15						į .	_
Ö	ohysic the b	Medical	that initiated events resulting in death) La	ast	·	Due to	(or as a co	onseque	nce of):				-				
	ding p			· ·	d										<u>.</u>	i .	
0	v requires that the death certific been signed by the ettending p should be deteched for use as	by Physician	Dort II Othor olanifle	cant conditions	contributing to a	looth but not ro	outting in	the und	la rheina a	auga di	von in Dert I		22h Did	tohanon ua	o contribut	to the co	use of death?
į	by the	hys	Part II. Other signific	t		1 /	#	trie und	enying c	ause y	veninraki	•		Yes 2			4 ☑ thknown
ກົ	gned ge del	by P	JYJUIT	tiple	De	cubit	1										
ecorus,	aquire en siç ould t			1									24a. Was	an autopsy ormed?	24b	available	opsy findings prior to
	law ra as be	Completed														of death?	n of cause
	The law cate has t	S											10	Yes 2₽1	46	1 🗆 Yes	2 € No
N Ed	iclen: certifi rector	Be	25. Was cese referre		Hospital:					Ot	hor:		h (Check only	-			
5	Phys	<u>د</u>	1 ☐ Yes 2 ☑ N 27. Manner of Death		1 1 1		☐ ER/Outp 28b. Tii			8c. Inju Wo	4 00 140		me 5 Res			ecify)	
UNISION	dlng th. : After	tion	1 XNatural 2 ☐ Accident	5 Pending investigat		of Injury oth, Day Yeer)		jury	М		rk? ]Yes 2.⊟	No					
<u> </u>	Atter or dea ector by the	iffice	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Plac	e of Injury - At ling, etc. (Spec	home, farr	m, stree	t, factory	, office			28f. Location	Street and N	lumber or F	Rural Route	Number,
5	tal or rs afte el Dir led in	Certification:	4 G Troillioide		Dunc	ing, etc. (Opec	<b>y</b> /						0.1, 0. 70	, 512167			
	To the Hospital or Attending Physicien: The law within 24 bours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical			Physician: To the aminer: On the band man												iuse(s)
	o the	<b>⊠</b>	29b. Signature and t	title of certifier				-	290	. Licen:	se number			29d. Dațe s	igned (Mor	nth, Day, Y	ear)
			Ama	tun H	Macel	n M	D		D	) /	550	03		Feb	12	_ 2	.004
	$\mathcal{C}$		30. Name and addre		o completed cau		em 23a) (T S T R			LTI	MORE	MAI	RYLAND	2121	7	)	
	Sta	te	31. Date filed (Month	h, Day, Yeer)		Begintrar's Sign				/					*		
	Registr		FEB 1	2 2004	The ask			/									

		For State Registrar	State of Man	•			ealth an Death	nd Mer		iene 19. No.	2004	043
Physicia /Medic	al .		olff			<del>-</del>	1	F	Date of Death Month ebruar	y 8.	Yeer , 2004 County of Deeth	3. Time of De 4:45P
Examin Funeral Director	iei	4a. Facility Name (If not institution, give 5904 Point Pleas 6. Security Number 6. Security Number 216-12-8466	ant Road	n yrs. last birthday) 80 Yrs.	В	altim r1Year	If Under 24	Hrs. 8.	Date of Birth (Month, Day, pril 6	Year)	Baltimor	
ס	Director	Usual Residence of Decedent	re 10	Dc. City, Town or Lo	'e	o Code			10	0g. Citiz	en of What Cou	10d. Inside City L 1 ☐ Yes 2
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	Funeral	5904 Point Plea:  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Sant Road  12. Was Decedent Eve Armed Forces? 11/21 Yes 2 □ No If Yes, Give Year or Dates:				spanic Origin n, Mexican, F Specify:	n? (Specify Puerto Rica			A.  4. Race - Amer Black, White Specify: Wh	, etc.
ed within 72 ho /giene. ior then "netu t, the Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)		dent's Usu kind of w DO NOT I Velde		ation during most of )			We	elding	ndustry
should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Robert E. Wolff  19a. Informant's Name/Relationship (7	iuna Printh	10b Maili	ng Addros	(Strant	Saral	n Mu	rray		Sumame) Town, State, Zi	in Codel
1 and 2 sh Health and em 27 ls n		Frances D. Wolff  20a. Method of Disposition	- Spouse		Poin	t Ple	easant		Balti	more		land 212
permit. Pages Department of I Important: If It any injury or o		1 Burial 2 Commation 3 1 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen:	)	Hilltop S	Servi 2. Name a	CE Co	orp. 2	Leon	4 ard J.	Tow:	son, Man	ryland
eath certificate be executed attending physician and attending physician and for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	onsequence of):	,	1.			colombly		n Ace fery	Interval Betwee
0 0 0	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the second of the se	Fetal death 3	⊒Ectopic p ⊒ Other (s					2	3d. Date of deliv	very Day Yea
The law requires that the ste has been signed by th bage 2 should be detache		Part II. Dther significant conditions or	ontributing to death but r	not resulting in the u	nderlying	cause give	en in Part I.			acco us		the cause of dear
	Completed								24a. Was ar autopsy perform 1 Yes 2	v .	24b. Were aut prior to co death? 1 \(\sum \) Yes	opsy findings ava ompletion of caus 2 \( \text{No} \)
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-CIEDIO		OA   Othe	ar.		heck only one			
ing After une	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury		28c. Injury Work	4 🗆 IAUISI		. Describe ho		Other (Special occurred	ny)
Hospital or Attend :4 hours after death Funeral Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, st Specify)	reet, facto	y, office		28f.	Location (Str City or Town		Number or Rur	ral Route Number
the Hospital thin 24 hours a the Funeral mpletely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Examone)	vsician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	h occurred vestigatio	at the time n, in my op	ne, date and p pinion, death	place, and occurred a	due to the ca at the time, da	use(s) a ate and	and manner as a place, and due t	stated. to the cause(s)
To the To the comple	Me	29b. Signature and title of certifier	Muns. 2		29	c. License	16 58	°7		40	signed (Month) ruang 10 MD 2	
					j	U	10 4.	*		,	and I a	7

		1	For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artment rtificate	t of H	ealth a Death	nd M		giene 2 Reg. No.	2004	04	348
	<b>-</b> 1 -1-1-		1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath _Day	Year	3. Time o	
	Physicia /Medic	al	Charles J. Wil:								02	05	2004	3:30	<b>P</b> M
*	Examin	_	4a. Facility Name (If not institution	, give street and num	ber)				Location o	f Death			ounty of Death To11		
			Continiim Care	6.504	7. Age (In yrs. Id	act hirthday		es <b>vi</b> .		24 Hrs.	8. Date of Bir	th		place (State	or Foreign
	Funeral	1	5. Social Security Number	6. Sex 7	87	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	Cou	Virgi	
	Director	-	521-36-1529 Usual Residence of Decedent		- 07						03				
	yland yland		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside (	
	a-fe	cto	Md Carro	11	Syk	esvil									s 2 No
	or 28	Director	10e. Street and Number		_		10f. Zip					-	n of What Cou	intry?	
	ath w	ra	7405 Village R			6 112 1		784	roanio Orio	rio2 (So	ecify Yes or No	U.S.A	Race - Amer	ican Indian	
	er de Item	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 ☐ Married</li> </ol>	Armed For		3.	If Yes, spec	ofy Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, White	, etc.	
36	Ir. or	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Da	9	ŀ	1 ☐ Yes	No	Specify:			Sp	pecify: Whi	te	
21215-0036	within 72 hours after death with the Maryland one. Than "natural", or Iteme 23a or 28a-f ehow he Modical Exeminer most be notified at	Completed by	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usua kind of wo	I Occupa	ation	of work	ina	16b. Kind	of Business/li	ndustry	
7	thin 7	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us	e retired	)						
N	ygien ygien her th t, the	ပ္ပြဲ	12	10		Truc	k Dri	ver	19 Matha	r'e Name	e (First, Middle		nsporta	ition	
ī	be filed within 72 hours after death with the Marylan at all tygiene.  All Hygiene and the how other than "natural; or Iteme 23a or 28a-f show other than "natural; or Iteme 23a or 28a-f show event, it is Marilan Examinat must be natified at	Be	17. Father's Name (First, Middle,	Last)							DeFoe	, maiden od	mamoj		
3	should be tand Mental I marked o	ဥ	Ernie Wilson 19a. Informant's Name/Relations	hin (Type Print)		19h Mailir	ng Address	(Street a			al Route Numb	er. City or T	own. State, Zi	ip Code)	
Maryland	d 2 sl th an t7 le r traur		Bernard J. Sach		nal Rep		3								1201
ē,	Heal Heal tem 2 other	11 31-	20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Nar	ne of			Date		tion - City or T		
ē	Pages ent of ht: If i		1 Burial 2 Cremation 4 Donation 5 Other (5	3 □Removal from S Specify)	state	ke Vie	w		ļ	2-09	9-2004	Sykes	sville,		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Ie marked any injury or other traumatic es		21. Signature of Funeral Service	Licensee		22 <b>87</b>	2. Name an <b>28 Li</b>	d Addres	s of Facility Roa	Lori	ing Bye Randall	rs Fur stown,	neral I , Md 21	Direct	ors In
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca	aused the death	n. Do not ent	ter the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approxima Interval Be	ate etween
į,	Physician		Immediate Cause (Final disease or condition	Tony one cause on the	deve	haa	10							Onset and	1 Death
1	/Medical		resulting in death)	a. Due to (	orasa cono⊨q	uence of									
	Examiner		Sequentially list conditions	b	C. V.	A .									
	D #	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (	or as a consequ	uence of):									
	cate be executed physician and the burial-transit	Examlner	that initiated events resulting in death) Last	c. Due to (	or as a consequ	1	10-00	Hy							
8760,	be ex cian burial		,	550.00	HT	N	1								
387	physicate sthe	edlcal		d											
9 X	eath certific attending pl	ZMe	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out		incy	¬					230	d. Date of deli-	very	
Вох	death a atter	Physician/M	in the past 12 months?	4 ☐ Pregna	irth 2□Feta ant at time of d		⊒Ectopic pi ⊒ Other <i>(sp</i>						Month	Day	Year
o.	at the de by the a	hys	9 Unknown	9□ Unkno	own			_							
ds, P.	es tha igned be de	2	Part II. Other significant condition R	ons contributing to de	eath but not res	ulting in the u	inderlying o	ause giv	en in Part I.			tobacco use Yes 2□I	contribute to No 3□Pro		death? ]Unkedwn
Vital Records,	w requir been si should	Completed	Chron	16 At	1.1	FIBE	Mak				24a. Was	an i	24b. Were au	topsy finding	s available
Rec	The lav ate has page 2 :	E D		1117	MEL	FIRE	Moci	CON				ormed?	death?	ompletion of	cause of
ā		ပို	25. Was case referred to medica	1					26 Place	of Deat	1 ☐ Yes h (Check only	2 No	1 1 105	2□ No	-
₹	yslcien: is certific director.	To B	examiner? 1 ☐ Yes 2 ☐ No	Moenital:	npatient 2	ER/Outpatie	nt 3 🗆 D0	Oth Oth	00		ome 5 ☐ Res		Other (Spec	cify)	
of	g Phy er this eral o		27. Manner of Death	28a. Date of		28b. Time o	-	28c. Injur Wor	y at		28d. Describe	how injury	occurred		
ion	Attending F death. ctor: After y the funera	atlo	Z L Accident	igation	,,, Duy , Jul.,	,	М		Yes 2□	No			_ 10/0		
Division	or Attending Physicien: uter death. Director: Atter this certific in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	nined 200. Flace	of Injury - At hong, etc. (Specif	ome, farm, st y)	reet, factor	y, office			281. Location ( City or To	(Street and I wn, State)	Number or Ru	ral Route Nu	mber,
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	edical Ce	(Check only 2 Medica	ng Physicien: To the Exeminer: On the ba	asis of examina	owledge, deal	th occurred	at the tir	ne, date an pinion, dea	nd place, ath occur	and due to the	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause	ı(s)
	thin 2 the 1 the 1 mplet	Med	one) 29b. Signature and title of dertifi	425	ner stated.		29	c. Licens	e number				signed (Month	n, Day, Year)	
	Twin o		160	JOHN	sily	MI	)	D - 0	005	42	18	02	-06.	-04	
	3		30. Name and address of person	B. Ker	e of death (Item	n 23a) (Type	Print)	(m	duis	re, b	vertw	1 hite	MD	2115	)
	St Regist	ate	31. Date filed (Month, Day, Year	2 2004 32.	egistrar's Signa	ature	rante	3							/
	riegisi	12.51				1									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Day 3. Time of Death 2. Dete of Death Month **Physician** DAVID WEINTZWEIG February 1330 /Medical 2004 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth Month Day, Year) MAR.5,1928 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) Funeral Days 1 M 2 □ F Months Hours 75 Yrs. MD 220-18-6116 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at page. 10d. Inside City Limits 1 ☐ Yes 2 🕅 No **Funeral Director** BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21208 7 POMONA SOUTH #8 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes 2 □ No Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify: WHITE 2 Specify: 3 Widowed 4 Divorced Year or Dates: Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHER PUBLISHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WEINTZWEIG **JOSEPH** ROSE BORNSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 POMONA SOUTH #8 - BALTIMORE, MD 21208 ROSALIE WEINTZWEIG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/04 PETACH TIKVAH CEMETERY ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Vedis Examiner Due to (or as a consequence of): Physician/Medical Examiner throm bocy topeni or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, potension Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No f TYes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this Director: After thind In by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ∏ Yes 2 ∏ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral DI completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29b. Signat@re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 2401 de Vander Nancy 32. Registrar's Signature 31. Date filed (Month, Day, Year) State and the FEB 1 2 2004 Registrar

WEINTZW

	1 - For State Registrar	State of Maryland / Dep.  Ce	artment of Health and M	lental Hygiene	2001. 01.250
	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physician	Inez le	salte :3		Johnson Day	182004 11:5 CAM
/Medical Examiner	4a. Facility Name (If not institution, give str	reet and number)	4b. City, Town, or Location of Death	4c.	County of Death
	Franklin sque	re Hospital	Rosedo 16		POILIWOIS
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday, M 2 X F 66 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec 18, 19.	9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	00 113.		Dec 10, 19.	57
and and	10a. State 10b. County	unk 10c. City, Town or L	ocation		unk 10d. Inside City Limits
Many Fed sh	MD				unk   Yes 2   No
Baltimore, Maryland 21215-0036  Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Model Examiner must be multied at once.  To Be Completed by Funeral Director	10e. Street and Number	un	K 10f. Zip Code	unk 10g. Cit	izen of What Country? USA
office death in them sea to interchant	11. Marital Status unk		Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
Pur Iter	1 Never Married 2 Married	Armed Forces?  1   Yes 2   No  When Care	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White, etc.
0336 purs 3	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	TEL 165 ZADINO SPECITY.		Specify: white
21215-00 ed within 72 ho sysiene. Per than "naturu it, it e Maxical Completed	15. Decedent's Educa (Specify only highest grade	completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing unk 16b. K	ind of Business/Industry unk
T21	Elementary/Secondary (0-12) unk un	College (1-4or 5+)	DO NOT use retired)		
d 2	17. Father's Name (First, Middle, Last)	.K	unk 18. Mother's Name	e (First, Middle, Maiden	Sumame) unk
and d be entat					
Maryland to 2 should be fit in and Mental H 27 Is marked oth treumatic even To Be	19a. Informant's Name/Relationship (Type	e, Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number, City o	or Town, State, Zip Code)
Maind 2	Franklin Square Hos	spital 900	O Franklin Square	Drive, Rose	edale, MD 21237
or Hear	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date 20c. Lo	ocation - City or Town, State
Page Page nent cant if ury or	'4 □Donation 5 ☑ Other (Specify)	in state			
Baltimore, permit. Pages 1 a Department of Hes Important: If them any injury or othe once.	21. Signal are of Funeral Stryice Licenses		2. Name and Address of Facility tate Anatomy Board altimore, MD 2120	655 W. Bal	ltimore Street
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deeth. Do not en	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Prevoucus			Onset and Death
/Medical	resulting in death)	Due to (or as a consequence of):			
Examiner	Sequentially list conditions. b.				
executed on and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
ecute and I-trans	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
2 8 E					
r a s s a r	d.				
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy	O5		23d. Date of delivery
death death drift	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O. hat the ded by the destached	9 Unknown	9□ Unknown		_	
S, F es lha igned be de	Part II. Other significent conditions cont		underlying cause given in Part I.		use contribute to the cause of death?
ould I	Coresmonuclar			1 ☐ Yes 2	
Division of Vital Records, for Attending Physicien: The taw requires I after death. Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed by	Rheunatic Hear	T Deale		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
on of Vital Rec ding Physicien: The lav h. After this certificate has funeral director, page 2:				1 ☐ Yes 2 🗷 No	
Vita icien: sertific ector.	25. Was case referred to medical examiner?	ospital:	Othor	th (Check only one)	
of Vita Physicien: this certific	TE Yes 2LANO	I Inpatient 2 de En Outpatie	ant 30 DOA 40 Notising the	ome 5 Residence 28d. Describe how inju-	
ding After funer	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury			
vitien death death y the	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,
Division C  Division C  tal or Attending P s after death al Director; After I ed in by the funers Certification:	4 Homicide	building, etc. (Specify)		City of Town, State	3)
Division o  To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th compietely filled in by the funeral Medical Certification.		icien: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.	tth occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause(s red at the time, date and	) and manner as stated. d place, and due to the cause(s)
To the within To the compl	29b. Signature and title of certifier	~	29c. License number	29d. Da	te signed (Month, Day, Year)
	> Thickare le	econolis	014667	01	-30-2004.
_	30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type	D19667 Franklin Square Dr	. 2 //.	11/1627
	Dr. Michael Sch	nwartz 7000 F	ranklin Square Ur	ive La I Amor	917d. XIDV
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	will some some some some some some some some		
- riegiotiti	FEB 1 2 2004	Marie De Labor			<u> </u>

			For	e Type or Print in State of Maryla	and / Dep		lealth and Mo	ental Hygie	ne	01.351
	Physici /Medic Examin Funeral Director	al	1. Decedent's Name (First, Middle, Harry S. Wo  4a. Facility Name (If not institution, S. Maille, Hospital)  5. Maille, Hospital  5. Social Security Number  214-20-0394	1f  nive street and number)  -a of Balt  Sex 7. Age (In )	\\ \( \mathref{WO} \times \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	4b. City, Town, o	Location of Death	Reg. 2. Date of Death Month Fels YUGYY  8. Date of Birth (Month, Day, 1ay 12,	Day Year 6 2004 4c. County of Dea	3. Time of Death 1745 M  thplace (State or Foreign ountry) orgia
	ith the Maryland or 28a-f show	Director	Usual Residence of Decedent  10a. State MD  10b. County  10c. Street and Number		City, Town or L Ba1	timore		10g	Citizen of What C	10d. Inside City Limits 1X Yes 2 □ No ountry?
920	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f show ta Modical Exertiret must be notified at	by Funeral Director	8911 Reisterst  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Ovorced	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H ff Yes, specify Cubs	J8 ispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- tican, etc.)	USA  14. Race - Am Black, Whi	
Maryland 21215-0036	filed within 72 ho Hygiene. other then "netur ent, 11 u Mexical	e Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Gollege (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of workin	g	o. Kind of Business electrica iden Sumame)	
Baltimore, Marylan	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hydene. Importent: If item 27 is marked other then "neturel; or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be notified at once.	To Be	Joseph Sch  19a. Informant's Name/Relationship  Susan Dudley/d.  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	aughter  Gramma Annual From State (city)	340 b. Place of Disp cemetery, cre		ce)	Route Number, C		
Ī	death certificate be executed  A	ilcal Examiner	21. Simplified of Funer Service Like ROLL ID S  23a. Party. Enter the disease, or content failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	11/1/1/11/1000	death. Do not en	tate Anat	omy Board MB 2701 Ig, such as cardiac of	655 W. E	altimore	Approximate Interval Between Onset and Death
P.O. Box	aw requires that the d s been signed by the 2 should be detached	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition	23c. If yes, outcome of print 1 Live birth 2 Life to the second of the s	Fetal death 3 of death 5	□Ectopic pregnancy □ Other (specify) □ underlying cause giv			2 ☑No 3 ☐ P	Day Year  to the cause of death?  trobably 4  Unknown  utopsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification; To Be Cor	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no 4 Homicide	28a. Date of Injury (Month, Day Yea	At home, farm, s	of 28c. Injui Wor M 1 🗆	y at 2 No	1 Yes 2 (Check only one) ne 5 Residence 8d. Describe how	No 1 □ Ye  e 6 □ Other (Speinjury occurred	s 2 PNo
)	To the Hospite within 24 hours To the Funerel completely filled	Medical C		Physician: To the best of my seminer: On the basis of examiner and manner stated.  T. Chart	mination and/or i	29c. Licens	ppinion, death occurre se number +85/	ad at the time, date	Date signed (Mon	e to the cause(s)  oth, Day, Year)
Di	St Regist		0 1 1-		ZZ, 243 Signature	35 W	Belveder	e Ave,	13-14,	mae MD

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yea **Physician** Allen James Marshall 7:15P M 2004 Jan /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LaPlata

| House 1 Year | Hours | Min. | Min. | March 16,1911 | South Carolina Civista Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F 92 Yrs. 099-16-8256 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic sysni, the Medical Examinar must be notified at Hughesville Yes 2 □ No Completed by Funeral Director Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20637 16763 Prince Frederick Road filed within 72 hours after death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Entrepreneur Allen Acres 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Heelth and Mental Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20637 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Heelth ar
Important: If item 27 is
sny injury or other trau Michelle Greenfield/Daughter 16763 Prince Frederick Rd Hughesville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem 1/29/04 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ) Odesoa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 002 dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Due to (or as a c Examiner The law requires that the death certificate be executed physicien and the buriat-transit Due to (or as a consequence of) Box 68760. Physician/Medicai the attending pl 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 2 2 No certificate 1 Yes 2 No 1 Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 **Zin**patient 3 DOA 2 1 Yes 25 No 2 ER/Outpatient this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after on Funeral Direct 4 T Homicide filled 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - Dan 0 4 D-31675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Akthar MD PO Box 1737 White Plains, MD 20695 U. Waheed 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Marshall

			1 - For State Registrar	State of Ma	•	artment of H		, ,	iene <sub>g. No.</sub> 200	14 04351
	Physic /Medi		Decedent's Name (First, Middle, I  William	M.	Abe		Sr.	2. Date of Deal Month FEBRUA	h Day Ye	3. Time of Death 04 17:55 M
	Examii		4e. Fecility Name (If not institution, g	ive street and number)	(In yrs. last birthday,	4b. City, Town, or  CUMBERLA  If Under 1 Year	Location of Death	1	4c. County of I	Deeth VY
	Funeral Director		215-42-4567 Usual Residence of Decedent	1 X M 2□F 5		Months Days	Hours Min.	May 14	, 1944	Birthplace (State or Foreign Country)
	Maryland -f show	tor	10a. State 10b. County  MD Allega		10c. City, Town or Le Cum	berland				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	Direc	10e. Street and Number 52 Elder Street			10f. Zip Code	21502	1	0g. Citizen of Wha	•
-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show odical Exeminer must be notified at	ted by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S <sub>I</sub> in, Mexican, Puerto Specity:		14. Race - /	American Indian, White, etc. White
21215-0036	d within giene. r than "	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	furing most of wor	king	Police De	
Maryland	d be enta ked	To Be C	17. Father's Name (First, Middle, Lateral James W. Abe	<u>,                                      </u>			Vertus	ne (First, Middle, M C. Santm	raiden Sumame) yire Abe	
	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship Patricia Abe	(Type, Print) sister	19b. Maili 187	ng Address (Street a 45 E. Wils	and Number or Ru son Rd SE	ral Route Number, Oldtov	City or Town, Sta VN	te, Zip Code) MD 21555
altimore,	Pages 1 and neut of Heamant: If Item		20a. Method of Disposition  1		20b. Place of Dispo cemetery, crei Sunset Mei	matory or other place	9)	2/9/2004	Cumberl	
Balt	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Lic	2 Aug	elli 2	2. Name and Address Scarpell 108 Viro			and, MD 21	502
8760,	Physician /Medical Examiner supply storage of the private of the p	dical Examiner	23a. Part1. Enter the disease, or co shock, of heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RESPIRAT( Due to (or as a  b. ENCEPHAL Due to (or as a	ORY FAILUR		y, such as cardiac	or respiratory arre	SI,	Approximate Interval Between Onset and Death 30 MINUTES 2 DAYS
.O. Box 6	death certif e attending ed for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P	sign d be	ed by PI	Part II. Other significant conditions TRANSPLANTED KII				on in Part I.			e to the cause of death?  Probably 4 Dunknown
al Records,	The law ate has b page 2 s	Completed by						24a. Was an autopsy perform	ed? prior death	e autopsy findings available to completion of cause of 1? Yes 2 \sum No
r Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatien	t 3 DOA Othe	_	h Check only one	nce 6 Other (S	Specify
	Attending Phys r death. actor: After this by the funeral di	Certification; T	27. Manner of Death  1 Natural 2 Natural 5 Pending investigation		/ear) 28b. Time of Injury	28c. Injury Work		28d. Describe how		pocity
É	Dire	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc.				City or Town,	State)	Rural Route Number,
	ne Hospitel n 24 hours a he Funerel I	edical	29a. Certifier  (Check only one)  1 Certifying F 2 Medicel Exa	hysicien: To the best of eminer: On the basis of eminer state	kamination and/or inv	n occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and d	as stated. due to the cause(s)
•	To the within 2 To the comple	W	29b. Signature and title of pertifier	osen W	0	29c. License	number (875)		d. Date signed (Me FEBRUARY	
	12		30. Name and address of person who WELIK, ROBERT A.	completed cause of dea		,	308 СТТ			
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's		M. A	200, 00.	TOTKLAND	, rm 213(	14

ATT1	EV. B	ERC	1 _ State		State	of Ma	aryland				lealth and l Death	Mental H	ygien Reg. N	- C U	104	0	35
			Registrar  1. Decedent's Name (First, Mid	idla Lasi	21				imouri			2. Date of I				3. Time	e of Death
	Physici	an	1. Decedent's Name (First, Mic	IUIO, LASI	,							Month	D	ay	Year		
	/Medi		Mattie V			Berg				_		JAN.		, 200		114	45 A M
	Examir	ner	4a. Fecility Name (If not institute GARRETT COUNT	_			SPITAI	ւ		LAND	Location of Deat	h	4		of Death		
-8	Funeral Director		5. Social Security Number	6. Se	x □M 2⊋F		e (In yrs. las	t birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of I (Month, May			9. Birthp Cour WV	place (Stantry)	te or Foreig
			233 66 5487 Usual Residence of Decedent									~ 1					
	Maryland -f show	tor	10a. State 10b. Cour					Town or Lo Garde:									e City Limits Yes 2⊠No
	the 28a	Director	10e. Street and Number				1		10f. Zip	Code			10g. C	itizen of	What Cou	ntry?	
	ath with	ral Di	Rt 1 Box 9	91 B				140.1		717	0-1-1-2 (0			SA	ce - Americ	ano lodiar	
920	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or Items 23a or 28a-f show event, it a Medical Examinal he notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ M 3 □ Widowed 4 □ Divord	100	12. Was Dec Armed F 1 Tyes If Yes, G Year or I	orces?		1	Vas Deced Yes, spec		ispanic Origin? (S an, Mexican, Puerl Specify:	to Rican, etc.)	No-		ck, White,		1,
15-0	72	Completed	15. Deced (Specify only hig			)		16a. Deced (Give life. L	ient's Usua kind of wo	al Occup rk done d	ation during most of wo	rking	16b.	Kind of B	usiness/In	dustry	
212	filed within Hygiene. other than	Comp	Elementary/Secondary (0-12)	2)	College	(1-4or 5	5+)		sewif						aking	J	
and	s 1 and 2 should be filed withir of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, item Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	To Be (	17. Father's Name (First, Midd Raymond Day		Grease:	r.					18. Mother's Nar Beat:	me (First, Midd rice Pa		en Sumai	пө)		
2	2 should and Men is marke	Ĕ	19a. Informant's Name/Relation					19b. Mailir	ng Address	(Street	and Number or Ri			or Town	State, Zin	Code)	
Baltimore, Maryland 21215-0036	permit. Pages Department of I Important: If the any injury or o		1 Serial 2 Crematic 4 Donation 5 Other 21. Signature of Funeral Servi	(Specify	)	n State		Lbaugl Lbaugl 22 E	n Cem	eter		Funeral itzmill	Hom	ne	rden, 1538	WV	
			23a. Part1. Enter the disease shock, or heart failure. L	or comp	lications that	caused	the death.							2_ كا	1330	Approxi	mate Between
D	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)		a	ubc	a conseque		mouto	ma	<b>a</b>					Onset a	and Death
4	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J	b. Dua to	o (or as	a conseque	nea of):									
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to	o (or as	a conseque	nce of):									
ox 6	leath certificate attending phy: I for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, o		of pregnance		Ectopic pr	annancy	,				ate of deliv		
O. B	that the deat red by the attr detached for	ysicie	in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown			gnant at	t time of dea		Other (sp				-	M	onth	Day	Year
ds, P.	uires that I signed by	by	Part II. Other significant cond	ditions co	ontributing to	death b	out not result	ing in the u	nderlying o	ause giv	en in Part I.			use con	tribute to t		of death? □Unknow
Division of Vital Records,	<b>ө</b> с <u>ө</u>	Completed										pe pe	tas an itopsy orformed? s 2 1	24b.	Were auto prior to co death?	opsy findion	ngs availab of cause of
ā	ilcian: Th certificate rector, pag	O	25. Was case referred to med	lical							26. Place of De						
of Vi	Attending Physician: r death. actor: Ater this certific. by the funeral director.	ToB	examiner? 1 XYes 2 □ No		_		ent 2 El	North State of the Land State of the			er: 4 🗆 Nursing I	Home 5 R	esidence			fy)	
n	ding P. h. After t funera	on:	27. Manner of Death 1 □ Natural 5 □ Per		28a. Date (Mo			8b. Time of Injury		8c. Injur War	rk?	28d. Describ	IN MOLL R	lary occu	ii eu		
isio	Attendii death. ctor: A y the fu	Certification:	2 Accident inversions 3 Suicide 6 Con	estigation uld not be ermined		ce of Inj	jury - At hom tc. (Specify)	1): 45 ie, farm, str	-		Yes 2 No	28f. Location	Street	and Num	€ V ber or Run	al Route I	Number,
Div	o it o	Certi	4  Homicide		buil	lding, et		inau				Mt St	Town, Sta	110) 1 い/			
	lospital of hours a uneral C	cai									me, date and place						se(s)

To the H within 24 To the Fu complete

29b. Signature and title of certifier

Nip 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

29c. License number

O.C.M.E

29d. Date signed (Month, Dey, Year)

JAN. 24, 2004

State Registrar

			1 - For State Registrar	State of M	aryland		artment of H rtificate of I		-	_	2001	04356
1		8	Decedent's Name (First, Middle)	ile, Last)					2. Date of De			3. Time of Death
	Physici /Medic		Henry	Josep			Butler		January	7 28,	2004 Year	1:50 A M
2008000	Examin	er	4a. Facility Name (If not institution	,			4b. City, Town, or	_	h		County of Death	
	Funeral	*	Washington Adv 5. Social Security Number	· · · · · · ·		ast birthday)	Takoma Pa	If Under 24 Hrs	8. Date of Bir	th	ontgomery  9. Birthp	lace (State or Foreign
	Director		577-34-1211	1 <b>∑</b> M 2□F	75	Yrs.	Months Days	Hours Min.	July 1	4,19	928 Washi	ington,DC
	land ow		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City,	, Town or Lo	cation				11	Od. Inside City Limits
	Mary a-f sh	tor	Maryland Charl	.es	Bran	dywine	9					1X Yes 2 □ No
	th with the 23a or 28	ai Dire	10e. Street and Number 3427 Malcolm F	Road			10f. Zip Code 20613				izen of What Coun JSA	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Evantinal must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce	MV-+ Ohio	10	46	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	)-	14. Race - America Black, White, of Specify: Bla	etc.
21215-0036	within 72 ho iene. 'than "natui Ine Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	nt's Education est grade completed)  College (1-4or	5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired CVISOT	ation furing most of wo )	rking		ind of Business/Ind	,
Maryland 2	ld be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle Joseph	H	But	ler		18. Mother's Na	ne (First, Middle,		Sumame) akle	
lary	2 shou and M Is mar	_	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street a	and Number or R		er, City o	r Town, State, Zip	Code)
	fealth fealth sm 27 ther tr		Helen Harringt	on/Daughter		17-17-17	ongfellow		ashingto			Chata
nor	ages int of h		1 ☐ Burial 2 🛣 Cremation  1 ☐ Donation 5 ☐ Other (				sition (Name of matory or other place Ltan Crema				cation - City or To Lington, V	
altimore,	permit. P Departme Importan any injur.		21. Signature of Funeral Service		Mec	_	. Name and Addres	1	731704	LT T.	ingcon, v	<u> </u>
m —	89 = 9	9 7	Couso	afei			dams Fune:				co, Maryl	
17.	Physician /Medical	*	23a. Part1. Enter the disease, on shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)	aa.	15 V	1 VO	er the mode of dying	Fails	or respiratory as	rrest,		Approximate Interval Between Onset and Death
w.	Examiner	_	Sequentially list conditions,	b. Due to (or as	inc	70	conc	er				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence or):						
60,	ficate be executed physician and s the burial-transit	ai Exa	resulting in death) Last	Due to (or as	a conseque	ence of):						
68760,	ficate physics the	edicai		d								
.O. Box	that the death certif ed by the attending detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deliver Month	ry Day Year
۵.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condit	ions contributing to death b	out not resul	iting in the u	nderlying cause give	on in Part I.			se contribute to the	\ \^*
Vital Records,	The ate h page	Completed							24a. Was autor perfo 1 🗆 Yes		prior to com death?	osy findings available inpletion of cause of
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medic examiner?	Hospital:	- 205	- -	Othe		th (Check only c		<i>-</i>	
Division of	ding Ph h. After th funeral	$\vdash$	27. Marher of Deal	28a. I te of Inju	iry 2	R/Outpatien 28b. Time of Injury	28c. Injury Work	at Nursing F	28d. Describe I		5 □Other (Specify, y occurred	
DIVIS	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could	mined   286. Place of In	iury - At hon c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and vn. State	d Number or Rural )	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edicai	29a. Certifier (Check only one) Certify	ing Physician: To the best I Examiner: On the basis o and manner st	i examinatio	riedge, death on and/or inv	n occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as sta place, and due to	ited. the cause(s)
<b>)</b>	To the within 2 To the complet	×	29b. Signature and title of certifi	19vss			29c. License	number ) 4 N	171	29d. Date	e signed (Month, G	Dy. Year)
(	Ban		30. Name and add ess of person	mpleted cause of c	leath (Item :	23a) (Type,	Print)	11001	1		D de	11000
	Sta	te	31. Date filed (Month, Day, Year	3 2004 32. Registr	ar's Signatu	ure .		UVUCI	ningfo	Dy	FTU	TIPHE
	Registr	ar	I LD V	2004	ر میں	J. 6	nesti s					

			For State Registrar	State of Mary		artment of i		d Ment		ene g. No. 2001	04357
			1. Decedent's Name (First, Middle, La						ate of Death	Day Year	3. Time of Death
	Physiciai /Medica	1	Jane Clair						an. 2	28, 2004	
	Examine	r	4a. Fecility Name (If not institution, gi				or Location of D	eath		4c. County of Dea	
			Civista Medi		yrs. last birthday			Hrs. 8. D	ate of Birth	Charle	rthplace (State or Foreign
- 1	Funeral Director	- 1		1□M 2XF 81	Yrs.	Months Days	Hours N	<sup>/in.</sup> De	onth, Dey, 1	7 <sub>0</sub> er) 1,1922 C	alifornia
	2	ļ	Usual Residence of Decedent	10	c. City, Town or L	nonting					10d. Inside City Limits
	show	5	10a, State 10b. County		Califo						1 ☐ Yes 2X No
	28e-f	900	Maryland St. Mo	агу	Calllo	10f. Zip Code			10	g. Citizen of What C	ountry?
	3a or	5	Wildewood			2061	9			U.S.A.	
5	death	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin	? (Specify )	(es or No-	14. Race - Am Black, Wh	
F ULP	or the	2	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give		1 ☐ Yes 2 XNo			,,	Specify: W	
5-0036	72 hours after death with the Maryland naturel, or items 23a or 28e-f show oreal Examiner must be notified at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Privorced	Year or Dates:	16a Dece	edent's Usual Occu	ination		1.	6b. Kind of Business	
ે હ 215-	in 72	olete	15. Decedent's E (Specify only highest gi	rade completed)	(Give	kind of work done  DO NOT use retire	during most of ed)	working	1	00. 14810 01 5001100	
€. 212	J within jiene. r then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	emaker				Her Hom	е
P	be filed ital Hygi of other event, I	Bec	17. Father's Name (First, Middle, Las	(1)						aiden Sumame)	
yla	should b nd Ment marked	0	Frank Lamb					ah I		Moore	
∟∩ ૯ Maryland	12 sh and r Is m raum	1	19a. Informant's Name/Relationship Christine Ston	(Type, Print) Daugh	ter 196. Mail	A 11:				City or Town, State, Md. 20	-
	t and Health sm 27 sthar to	1	20a. Method of Disposition	2	20b. Place of Disp	osition (Name of nmatory or other pl	Lane,	Date	2	Oc. Location - City o	
, . on	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, cre Metropo	matory or other pi litan F	<sup>ace)</sup> Feb. 'uneral	3,2	004 Vice	Alexand	ria,Virgini
altimore,	그 문문을 .		21. Signature of Funeral Service Lice			2. Name and Add	ress of Facility		11.0		
ä	Deparent Dep		Wish hill		M00668	4270 E	lms Fun Lawthor	ne R	d., I	P.A. Indian H	20640 ead, Md.
ė.			23a. Pert1. Enter the disease, or con shock, or heart ailure. List ont	nplications that caused the y one cause on each line.	death. Do not er	iter the mode of dy	ring, such as car	diac or res	oiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Pre	rwo.	ma					week
	/Medical Examiner		Tesuring in death)	Due to (or as a co	onsequence of:	, ,					NAGE
1	parent le	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	risequatice of):	X (V)					0
	be executed sician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
ó	te be executed ysician and to burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	9 % 9	dicai	•	d							
x 68	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of p	regnancy					23d. Date of de	elivery
Вох	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No	1 Live birth 2 □ 4 Pregnant at time	Fetel death 3	□Ectopic pregnan □ Other (specify)	су			Month	Day Year
P.O.	that the de led by the a detached t	hysi	9 Unknown	9□ Unknown							
	as the day	by P	Part II. Other significant conditions	contributing to death but ne	ot resulting in the	underlying cause g	iven in Part t.			ath 5	to the cause of death?
Vital Records,	w require been sis							-	1 ∐ Yes		Probably 4 □Unknown
ec	has b	Completed						_   '	24a. Was an autopsy perform	24b. Were a prior to death?	autopsy findings available completion of cause of
<u>=</u>	ician: The law certificate has rector, page 2 s								☐ Yes 2	No 1 □ Ye	s 2 No
Zi.	Physician: this certifical	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	2 ☐ ER/Outpatie	2 100A			eck only one 5 □ Besider	nce 6 ⊡Other (Sp	ecrity)
of	g Phy er this eral d	<b>-</b>	27. Manner of Death	28a. Date of Injury (Month, Day Ye		of 28c. In:				w injury occurred	SUNJ/
<u>io</u>	Attending Fir death. sctor: After by the funer	atio	Pending  2 ☐ Accident  5 ☐ Pending investigate	ion	ser/ injury		JYes 2 □ No				
Division of	or Atter de Diracto in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, s Specify)	treet, factory, office	9		ocation (Str. City or Town,	eet and Number or F State)	?ural Route Number,
۵	oital o urs af eral D		CO. Carifica M. Carifaina	Physician: To the best of m	w knowledge des	th coursed at the	time data and s	lana and a	lun to the ea	uso(a) and manner	as stated
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		eminer: On the basis of example and manner stated	amination and/or i						
	To the within To the comple	Me	29b. Signature and title of certifier	1		29c. Lice	nse number		29	d. Date signed (Mor	nth, Day, Year)
			3, M. A.	Helehan	N. MW	D-	46046		1	-29-	-2004
\			30. Name and address of person wh	o completed cause of deati	(Item 23a) (Type			О. В	ox 18	90	•
	135		Amir A. Mirza 31. Date filed (Month, Day, Year)	a Alikhani,	MD 11	8 La Gr	ange A	venue	e La	Plata, N	1D 20646
	Stat Registra		FEB 03	32. Rojistrar's	0 10	Sperke					

			1 - State of Registrer	Maryland / Depa	artment of H	lealth and D <i>eath</i>		ene 2004	04358
	Physici		1. Decedent's Name (First, Middle, Last)  Laura Augustine Borchelt	-			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or	Location of Dea	February	1, 2004 4c. County of Death	
			Fort Washington Hospital			ashingto		Prince (	
	Funeral Director		5. Social Security Number  492–16–7209  Usual Residence of Decedent	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			nplace (State or Foreign untry) Illinois
	yland how		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director	Maryland Prince George'	s Accokeek					1 ☐ Yes 2√∑ No
	with the	급	10e. Street and Number 14695 West Ridge Road		10f. Zip Code	0607	100	g. Citizen of What Co	untry?
	death	Funeral	11 Marital Status 12. Was Dece	dent Ever in U.S. 13.	Was Decedent of H if Yes, specify Cuba		Specify Yes or No-	U.S.A.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other traumatic evant, ite Medical Examinat must be notified at once.	þ	Armed For 1 Never Married 2 Married 1 Yes If Yes, Giv. Year or Da	2X No	if Yes, specify Cuba 1 ☐ Yes 2 <mark>전</mark> No	n, Mexican, Pue Specify:	rto Rican, etc.)	Specify: W	hite
Maryland 21215-0036	72 ho 'netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking 16	6b. Kind of Business/l	ndustry
7	within ane. then	ldu	Elementary/Secondary (0-12) College (1-12)	-4or 5+)	DO NOT use retired memaker	0		Her home	
2 2	Hygin othar ant,	Be Co	17. Father's Name (First, Middle, Last)		menerici.	18. Mother's Na	me (First, Middle, Ma		
/lan	uld be Menta Irkad Itic ev	To B	William Crockett LeMay			Olive	e Kimball		
Aar)	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print)  Archie R. Borchelt (hus		,		ural Route Number, (		,
ė,	1 and Health am 27 ther t		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		d; Accokee	K, Marylar Oc. Location - City or 1	
Baltimore,	Pages ant of nt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	comptany crar	natory or other plac	renn	ary 7, 20		
aĦi	partm portar y inju		21. Signature of Funeral Service Licensee		2. Name and Addres		Villiams F		
<u> </u>	89589	U.J	Malentlem	M00668 4:	270 Hawth	orne Roa	d: Indian	Head, Mar	yland 2064
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that of shock, or heart tarure. List only one cause on extendiate Cause (Final disease or condition resulting in death)  Due to (condition)	there sclerot or as a consequence of):				disease	Approximate Interval Between Onset and Death UNFROWN
8760,		Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	or as a consequence of): or as a consequence of):					
P.O. Box 68	ath certifi attending for use as	Physiclan/Medical	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to de Hyper ten 5100	ath but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	The law red ite has bee bage 2 shor	Completed	J'		<del></del>		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
<u>ta</u>	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				ath (Check only one)	3110	
<u>o</u>	Attanding Physician: ar death. actor: After this certifics by the funeral director. E	ို	Yes 2 No Hospital: 1 ☐ Ir 27. Manper of Death 28a. Date of	npatient 2K ER/Outpatien		4 🗀 Nursing i	Home 5 Residence		ify)
on	ding I h. After funer	tlon	1 Natural 5 Pending (Month	h, Day Year) Injury	Work	rat <br Yes 2 ⊟No	28d. Describe how	injury occurred	
Divisi	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be	of Injury - At home, farm, str ag, etc. (Specify)			28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	To tha Hospital or A within 24 hours after To the Funerel Dira completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physician: To the ba and mann	sis of examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Month,	Day, Year)
			) Decel	M(I)	D4	6741	Fe	broary 1,	2004
1	BE	- 4	29b. Signatura and title of certifier  30. Name and address of person who completed cause  Deepa K Sachdeva, M. C  31. Date filed (Month, Day, Year)  FEB 0 3 2004	of death (Item 23a) (Type,	Print)	Ta D	162	110000	20744
1	Sta	te	31. Date filed (Month, Day, Year) 32. Re	strar's Signature	1VIHGS	107 UCC	1 ront 6	NAS HING TE	n ina.
	Registr		FEB 0 3 2004	were It A	parte				

		•	1 - For State Registrar	State of Mary		artment of H		Reg. I	- / IIII lu	04359		
	Physicia /Medic Examin	al	MILDRED MARIE BANCROF'I'  JAN. 24, 2004  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Deeth  4c. County of Deeth							3. Time of Death 3:10 P M		
Di	uneral rector		CARROLL HOSPI7  5. Social Security Number 6. S  172-16-0603  Usual Residence of Decedent		n yrs. last birthday 83 Yrs.		IINSTER If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Yea 8 / 1 4 / 1 9 2		ptace (State or Foreign ntry) JERSEY		
<b>-UU36</b> hours after death with the Maryland	nt of Health and Mental Hygiene.  It if tem 27 is marked other than "natural", or flems 23s or 28s-1 show y or other traumatic event, the Medical Exertical must be notified at	Director	10a. State         10b. County         10c. City, Town or Location           MD •         CARROLL         WESTMINSTER           10e. Street and Number         10f. Zip Code           66 MADISON ST .         21157						10d. thside City Limits 1 ☑ Yes 2 ☐ No  10g. Citizen of What Country?  USA			
<b>J36</b> urs after death w		by Funeral	66 MADISON ST  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No			14. Race - American Indian, Black, White, etc.  Specify: WHITE			
d Z1Z15-UU36 filed within 72 hours aft Hygiene.		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12) 1 2	College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired HOUSEWI	Kind of Business/Ir					
ylan Suld be Mentai		To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Malden Surname)  ADET. ATNE HARTES							o Code)		
Ore, jes 1 an of Heal			KAY FOGLE  20a. Method of Disposition  1 □ Burial 2 【Cremation 3 5  4 □ Donation 5 □ Other (Speci	Removal from State	20b. Place of Disp	osition (Name of	(a)	TMINSTER Date 200. /28/04 S	Location - City or T	own, State		
baltim permit. Pag Department	Important: F any injury o once.		21. Signature of Funeral Service Lice	tel )	25	54 E. MA	IN ST.,	ETCHER F				
/M Exa	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and more possible to the Funeral director, page 2 should be detached for use as the burial-transit of by the funeral director.	Examiner	23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus in each line.  Immediate Cause (Final disease or condition resulting in death)  a.     Due to (or as a consequence of):									
Records, P.O. Box 68/60, The law requires that the death certificate be executed		Physician/Medical Ex	d.							23d. Date of delivery Month Day Year		
rds, P.(		ρ	Part II. Other significant conditions	contributing to death but n		e contribute to the cause of death?						
		Completed	25. Was case referred to medical	24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings a prior to completion of ca death?  1 ☐ Yes 2 ☐ No  26. Place of Death (Check only one)						empletion of cause of		
on of Jing Phy J.		Certification: To Be	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Resid							dence 6 Other (Specify) now injury occurred Street and Number or Rural Route Number,		
Diy To the Hospital or within 24 hours afte		Medical Cer										
	1	Me	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						29d. Date signed (Month, Dey, Year)			
	Sta Begist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	291 5	sieven	AUPNUR G	LUPSIMI	Maryan		

			1 - For St <i>e</i> te Registrar	State o	f Marylan		artment of rtificate of		and Me		iene <sub>eg. No.</sub> 2	004	04360		
	Physici /Medio	al	1. Decedent's Name (First, Middle Reda Cordelia	Bostian	nh orl		4b. City, Town,	or Location o		2. Date of Deal Month	Day	Yeer 04	3. Time of Death		
	Examir	er	4a. Facility Name (If not institution Brookfield Mano 5. Social Security Number	_		last birthday)	Middle  If Under 1 Year	burg		8. Date of Birth	Car	roll	nplace (State or Foreign		
	Funeral Director		214-74-8808 Usual Residence of Decedent	1□M 2X1F	99	Yrs.	Months Days	Hours	Min	Jan. 8,	1905	Mary	and		
ore, Maryland 21215-0036	he Marylan 28e-f show criffical at	ector	Maryland Carro	11		y, Town or Lo Keymar				1,	On Citizan	of Minat Co.	10d. Inside City Limits 1 ☐ Yes 2 No		
	Geath with t	Completed by Funeral Director	10e. Street and Number 5748 Middleburg 11. Marital Status		edent Ever in U	.S. 13.	10f. Zip Code 21757 Was Decedent of If Yes, specify Cu		gin? (Spec		USA 14. F	of What Cou Race - Amer Black, White	ican Indian,		
	hours after turel', or ite	ed by Fu	1 □ Never Married 2 □ Married 1 □ Yes 21□ No				1☐ Yes 2∕☐ No	es \$∕□ No <i>Specity:</i>					Specify: White Kind of Business/Industry		
	ed within 72 giene. er then "na . If a Medic	Complete	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  Homemaker						g	Own Home					
	nould be file d Mental Hy narked oth natic event	To Be (	17. Father's Name (First, Middle, Edward A. Stra	wsburg		10h Maili	ng Address (Stree	Harr	iet l	(First, Middle, M Miller			in Codel		
	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel; or Items 23a or 28e-1 show any in ury or other treumatic event, the Medical Everaliset mast be notified at once.		June C. Shankle  20a. Method of Disposition  1 2 Burial 2 Cremation	/daughter	State	1034 Place of Dispo	5 Woodsb sition (Name of matory or other pl	oro Ro	oad, N	woods bo	ro, Mo 20c. Locatio	d. 217 on - City or T	798 Town, State		
Baltimore,	permit Pag Deparment Importent: any in ury c		'4 □ Donation 5 □ Other (S 21. Sign tyle of Fuheral Service	ipecity)	Dlew		Cemetery Name and Addi E. Broad			9,2004 tzler F Bridge					
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Interval Between				
Box 68760,	death certificate be executed e attending physician and ind for use as the burial-transit	Physician/Medical Examiner	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d	(or as a consequence of pregnation of pregn	ancy	⊒Ectopic prøgnan:	04				Date of deliv	,		
P.O. B	t the by th ache		in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of death 5 ☐ Other (specify)						1	Month Day Year				
	requires een sign nould be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown				
al Rec	The lay ate has page 2	Completed by	Kenal Facture								prior to completion of cause of death?  2 No 1 Yes 2 No				
Division of Vital Records,	는 다 는	ation; To Be	examiner? 1   Yes   2 No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Ho						rsing Hom						
Divis	in Diffic	Certification:	4 Homicide building, etc. (Specify)						28f. Location ( <i>Street and Number or Rural Route Number,</i> City or Town, State)						
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  2 Medical (Medical one)		best of my kno asis of examina ner stated.	wledge, death tion and/or in	vestigation, in my	time, date an opinion, deat	d place, ar th occurred	d at the time, da	ate and plac	manner as s e, and due t ned (Month,	to the cause(s)		
	WY S	(	1 A	who completed caus	te fi doub (tre	239) //	1	0000	906	,	- 1 -	26/5	24		
	Sta	te	30. Name and address of person  31. Date filed (Month, Day, Year)	EMD.	295 legis <b>y</b> ar's Signa	Such	ER JO	HK	1500	ed Llu	ian E	Ridge	M 9522		
	Regist		JAN 2	2 8 2004	Glower	K	Location								

		State of Maryland / Department of Health and  1- State  Certificate of Death	d Menta	al Hygiene Reg. No	CVUY	04361
		1. Decedent's Name (First, Middle, Last)	2. Dat	te of Death	·-	3. Time of Death
Physic	cian	James Bell	Jan	uary 20	, 2004	6:15 A M
/Med		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De			. County of Deatl	
Exam	iner	Table ( Table )	02		-	
	<b>%</b> .	5935 Rosevelt Place Bryantown  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F	Hrs. 8 Dat	te of Birth	arles 9. Birti	nplace (State or Foreign
Funera Directo		Od Od Od Od Od Od Od Od Od Od Od Od Od O	Ain. (Mo	onth, Day, Year)	Co	intry)
Directo	r e	Usual Residence of Decedent	rebrua	ry 22, 1	916 Mary	Tand
tand ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Marylan f show	ō	Mars 1 - 1   2 - 1 - 2   December 2				1 ☐ Yes 2 ☐ No
vith the Maryla or 28e-f shove	Director	Maryland Charles Bryantown  10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Co	untry?
with sa or		5935 Rosevelt Place 20617		11	SA	
nours after death wit urst', or items 23s of Examiner must be	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	? (Specify Ye	es or No-	14. Race - Ame	
ter o	듄	Armed Forces? If Yes, specify Cuban, Mexican, Pu	uerto Rican,	etc.)	Black, White	
urs a	þ	If Yes, Give 1 ☐ Yes 2 🗓 No Specify: Year or Dates:			Specify: Bl	.ack
filed within 72 hours after death with the Maryland Hygiene. Hygiene "naturs!", or Items 23a or 28e-f show ent, tre Medical Examinat must be rediffed at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of the complete of the co		16b. K	(ind of Business/	ndustry
7 uin 7	P e	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	working			
i the	E	12 Bus Driver		Kel	ler	
at,	BeC		Name (First,	Middle, Maider	n Sumame)	
id be enta ked	To B	Thomas Albert Bell Mary		Young		
s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, tra Medical	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	r Rural Route	Number, City	or Town, State, Z	ip Code)
and 2 and 2 nealth at 127 is		Joseph A. Bell/ Son 37135 East Winston Dr	r Mach	ani cessi	lle Mars	20659
ten 1 a		20a Method of Disposition 20b. Place of Disposition (Name of	Date		ocation - City or	
Pages nent of h ant: If It		1 \( \text{Burial 2 \( \text{Cremation 3 \( \text{Removal from State} \)} \) 1 \( \text{Burial 2 \( \text{Cremation 3 \( \text{Removal from State} \)} \) 1 \( \text{Dogation 5 \( \text{Other (Specify)} \)} \) 1 \( \text{St. Marys Cath Ch Cem 1 / } \)	/27/04	Brva	ntown, M	arvland
it. P		. 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility		7-10		7
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is merked other than any injury or other traumatic event, Item and item in the Mental Ment	OIK	NO01. 04104	7. C on	7 cm a cm	ao Morr	land.
Art .		MO1323 Adams Funeral Hom  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card			co, mary	Approximate
	4	shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Metastatic Prostate Ca	ma			months
/Medica Examine		Due to (or as a consequence of):				
LXAIIIIIC		Sequentially list conditions, b.				
P :	Examiner	if any, leading to immediate cause. Enter Underlying				
ecute and trans	la m	Cause (Disease or injury that initiated events c				
cate be executed only sician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
ate b	Physician/Medical	d				
ng p	Vec	IF FEMALE:				
th ce	an	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Dale of deli	very Day Year
dea dea ed fo	SC	in the past 12 months?  1  Yes 2 No  9 Unknown			WONTH	Day Tour
by ti	ly.	9 Unknown				
ss than	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23		at a	the cause of death?
aquir en si		memia	-	1   Yes 2	No 3□Pr	bably 4 Unknown
aw re	Completed		24	a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
The I	E		1.5	performed? ☐ Yes 2 No	death?	2 No
In In In In In In In In In In In In In I	l es	25. Was case referred to medical 26. Place of I			12.03	20110
s cert	0 0	examiner?		,	6 ☐Other (Spec	ifv)
P P C	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	-	scribe how inju		
fr. Att	ē	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
Atter dea	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Lo	cation (Street a	nd Number or Ru	ral Route Number,
affe affe	ert	4 Homicide determined building, etc. (Specify)	Cit	y or Town, State	θ)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plants.	lace, and due	e to the cause(s	and manner as	stated.
e Ho 24 h Fui etely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	occurred at th	ne time, date an	d place, and due	to the cause(s)
ompl	₹	29b. Signature and title of certifier 29c. License number		29d. Da	ite signed (Month	, Day, Year)
F 5 F 0	İ	DE Cato bell DE906	, ,		1/20/	U
200		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	01		1/2010	1
クロン		1 1 2 2 1 1 100	Deven F	redecicle.	MA 10	78
W 45 C	State	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	LINCE II	- CHELLE	IN:12 KO	<i>F</i> ' \
Regis		JAN 2 7 2004 Streve St. Speele				

Physician Medical Examiner  Medical Examiner  Melvin Eugene Boyer  4a. Fecility Name (If not institution, give street and number)  4a. Fecility Name (If not institution, give street and number)  Frederick Memorial Hospital  Frederick  S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. a. Date of Binh Months Days Hours Min. June 4. Was a Decedent Total To	Day Year 25, 2004 8:45 A M 4c. County of Death Frederick  Frederick  Year) 9. Birthplace (State or Foreign County) 1931 Maryland  10d. Inside City Limits 1 Yes 2 No No. No. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White 6b. Kind of Business/Industry  Automotive Industry  Faiden Sumame)
Medical Examiner   Medical Examiner   Melvin   Eugene   Boyer   January	Day Year 25, 2004 8:45 A M 4c. County of Death Frederick  Frederick  Year) 9. Birthplace (State or Foreign County) 1931 Maryland  10d. Inside City Limits 1 Yes 2 No No. No. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White 6b. Kind of Business/Industry  Automotive Industry  Faiden Sumame)
Medical Examiner   Melvin Eugene Boyer   4a. Fecility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   Frederick   Frederick   Frederick   S. Social Security Number   S. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month), Days   Hours   Min.   June 4, Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Maryland   Frederick   Trederick   Frederick   10a. State   10b. County   10c. City, Town or Location   Maryland   Frederick   Trederick   Trederick   10b. Street and Number   10b. County   10c. City, Town or Location   Trederick   Trederick   10b. Street and Number   10b. Street   10b. Street and Number   10b. Street   10b.	Frederick  9. Birthplace (State or Foreign Country) 1931 Maryland  10d. Inside City Limits 1  Yes 2  No  No. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White 6b. Kind of Business/Industry  Automotive Industry  Faiden Sumame)  Y
Second Security Number   Second Security Num	9. Birthplace (State or Foreign Country)  1931    Maryland     10d. Inside City Limits   1
Second Security Number   Second Security Num	9. Birthplace (State or Foreign Country)  1931    Maryland     10d. Inside City Limits   1
Director    Comparison of the property of the	1931 Maryland    10d. Inside City Limits   1
Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Maryland  Frederick  10c. City, Town or Location  Maryland  Frederick  10c. City, Town or Location  Maryland  Frederick  10c. City, Town or Location  Maryland  Frederick  10c. City, Town or Location  Maryland  Frederick  10c. City, Town or Location  10c. City, Town or Location  Maryland  Frederick  10c. City, Town or Location  10c. City, Town or Location  Frederick  10c. City, Town or Location	Inited States  14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Automotive Industry  Auden Sumame)
Specify only highest grade completed   College (1-4or 5+)	og. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Automotive  Industry  Faiden Sumame)  Y
Specify only highest grade completed   College (1-4or 5+)	United States  14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Automotive Industry  aiden Sumame)
Specify only highest grade completed   College (1-4or 5+)	United States  14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Automotive Industry  Auden Sumame)  y
Specify only highest grade completed   College (1-4or 5+)	United States  14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Automotive Industry  Auden Sumame)  y
Specify only highest grade completed   College (1-4or 5+)	14. Race - American Indian, Black, White, etc.  Specify: White 6b. Kind of Business/Industry Automotive Industry aiden Sumame)
Specify only highest grade completed   College (1-4or 5+)	Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Automotive  Industry  Faiden Sumame)
Specify only highest grade completed   College (1-4or 5+)	6b. Kind of Business/Industry Automotive Industry  (aiden Sumame)
Specify only highest grade completed   College (1-4or 5+)	6b. Kind of Business/Industry  Automotive  Industry (aiden Sumame)
The property of the property o	Automotive Industry  (aiden Sumame)
The property of the property o	Industry (aiden Surname)
The property of the property o	laiden Sumame) Y
Charles M. Boyer  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mary E. Berry  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mary E. Berry  19a. Informant's Name/Relationship (Type, Print)  19c. Mary E. Berry  19a. Informant's Name/Relationship (Type, Print)  19c. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mailing Address (Street and Number or Rural Route Number, Print)  19c. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, Print)  19d. Mailing Address (Street and Number or Rural Route Number, P	у
Charles M. Boyer  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Variety of Frederick Crematory or other place)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Variety of Street and Number or Rural	
20a. Method of Disposition   Date   20b. Place of Disposition (Name of cemetery, crematory or other place)   1   Burial 2   Cremation 3   Removal from State   4   Donation 5   Other (Specify)   Frederick Crematory   1/30/04   21. Signature of Funeral Service Licensee   22. Name and Address of Facility Stauffer Fu	City or Town, State, Zip Code)
20a. Method of Disposition   Date   20b. Place of Disposition (Name of cemetery, crematory or other place)   1   Burial 2   Cremation 3   Removal from State   4   Donation 5   Other (Specify)   Frederick Crematory   1/30/04   21. Signature of Funeral Service Licensee   22. Name and Address of Facility Stauffer Fu	,
1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  1 Donation 5 Other (Specify)  1 Signature of Funeral Service Licensee  1 Signature of Funeral Service Licensee  1 Signature of Funeral Service Licensee  1 Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Service Licensee	ick, Maryland 21701
The Burial 2 by Cremation 3 Hemoval from State  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Service Licensee  1621 Opossumtown Pike Fred	0c. Location - City or Town, State
21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer Fu	Frederick, Maryland
a a a a a a a a a a a a a a a a a a a	
FINITE THE TELL	
Z3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre	
shock, or heart failure. List only one cause on each line.    Immediate Cause (Final   Duruno Moutou   months   1	Interval Between Onset and Death
disease or condition	i days
/Medical resulting in death)  Due to (or as a consequence of):	5.1.8
Sequentially list conditions b.	o squs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Cause (Disease or injury that initiated events c.	
Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
1	
Q = 0 a 0	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1	23d. Date of delivery
in the past 12 months?  I yes 2 No  In the past 12 months?  I yes 2 No  I yes 2 No	Month Day Year
O et a to be a be a be a be a be a be a be a be	
	acco use contribute to the cause of death?
\$ & End Stack Kenal Disease	2 No 3 Probably 4 Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tob  1   Ye  24a. Was ar  autopsy perform 1   Ye s   2  25. Was case referred to medical examiner?  Hospital: M. Sport of the contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tob  24a. Was ar  autopsy perform 1   Ye s   2  25. Was case referred to medical examiner?  Hospital: M. Sport of the contributing to death but not resulting in the underlying cause given in Part I.  25e. Did tob  26e. Place of Death (Check only one	04. 11
24a. Was ar autops) perform	prior to completion of cause of
	ed2 death? No 1 Yes 2 No
1   Yes 2   25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  1   Yes 2   25. Was case referred to medical examiner?  1   Yes 2   25. Was case referred to medical examiner?  26. Place of Death (Check only one Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Resided   Check only one   28   Describe how   28   D	)
	ice 6 ☐Other (Specify)
27. Manyer of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how Injury Work?	v injury occurred
To be a second of the second o	
To be a seried of the seried o	eet and Number or Rural Route Number,
27. Manyfer of Death 1 Natural 2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   5   Pending investigation   6   Could not be determined   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   28d. Describe hor investigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Str. City or Town, office   City or Town	State)
Second Property of the control of	use(s) and manner as stated.
and manner stated.  29b. Signature and title of certifier  29c. License number	
29b. Signature and title of certifier  29c. License number	d. Date signed (Month, Day, Year)
Mall lifer	1 21.04
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 1 . L
17 WOOL 12 FOXES - 2011 15011	IT INP ANDADICK.
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar  32. Registrar  32. Registrar	rive trederich

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Month Physician January 27, Gary John Backus 2004 1:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1⊠M 2□F Months Days 113-44-7735 50 Director New York Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Marvland Frederick 1xx Yes 2 □ No Funeral Director Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 East 4th Street, Apt. 3 21701 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2021 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2824No Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Regional Manager Landscaping 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Backus Rita M. Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Peter Backus / Son 424 East Patrick St.; Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Jan. 28, 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2004 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licensee 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part Enter the disease, or compli-shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires thet the death certificate ba axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of). Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobecco use contribute to the cause of death? 1 Ves 2□ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? has TO Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA : After this a funeral di 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Director: At completely filled in by tha fu investigation 1 Yes 2 □ No efter death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 — certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 3 (4 NYJW

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day,

32. Registrer's Signature

			For State Registrar	State of Ma	-	Department of F Certificate of a			iene 200	4 04364
	Physici /Medic		1. Decedent's Name (First, Middle,		Beck	Sr		2. Date of Death Month	Day, Th Year	3. Time of Death 4 11/33 p. M
1	Examin	_	4e. Facility Name (If not institution, Howard Con	nty gener		Ce	r Location of Death		4c. County of Dec	rard.
	Funeral Director		5. Social Security Number  174-28-1582  Usuel Residence of Decedent	6. Sex 1 M 2 ☐ F 64	(In yrs. last bin	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 21, 1		nthplece (State or Foreign ountry) nnsylvania
	Maryland -f ehow	tor	10a. State 10b. County MD Howard	đ	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ims 23a or 28e-f ehow r.must be notified at	al Director	10e. Street and Number 4108 Flintlock	Court		10f. Zip Code	1737		og. Citizen of What C United St	
036	or Its	by Funeral	11. Marital Status  1 Never Married 2 Amarrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	1958-	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Am Black, Wh	erican Indian,
21215-0036	within 72 ho ane. than "natu	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired enior Colsul	during most of work d)	ing	Contract	
Maryland 2	should be filed and Mental Hygie marked other matic event, III	To Be C	17. Father's Name (First, Middle, L Ralph Beck	ast)			18. Mother's Name Doroth	e (First, Middle, M y Miller		
	nd 2 shallth and 27 is m		19a. Informant's Name/Relationsh Linda J. Beck/Wi		41	Mailing Address (Street 08 Flintloc	k Court G	lenelg,	MD 21737	
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition	ecify)	Willia	Disposition (Name of ry, crematory or other place msburg Memo:	rial 1 <b>-1</b> 9	-2004		urg, Virginia
Ba	Departi Departi Importa any inji		21. Signature of Funeral Service L	ins- With	the death Do	4112 Old Co	olumbia P	ike Ell	icott Cit	mily FH, Inc. v, MD 21043
8760,	Create be executed /Medical physician and Examiner sthe burial-transit	dical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a b.  Due to (or as a c.	Δ .	Seniral  91: epti c  on: on:	-		-	Interval Between Onset and Death
O. Box 68	ath certif ttending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of de Month	elivery Day Year
rds, P.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant condition		it not resulting in		en in Part I.	23e. Did tob	\_/	to the cause of death?
il Records,		Completed	V	,				24a. Was ar autopsy perform 1 Yes 2	/ prior to ned? death?	utopsy findings available completion of cause of s 2 \( \sum \) No
Division of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1	ation of he	Year) 28b. 7	Time of 28c. Injury Wor 1	er: 4 □ Nursing Ho	28d. Describe ho	nce 6 □Other (Spewinjury occurred	
N N	pital or Attendurs after death ours after death erel Director: filled in by the		4 Homicide determi	g Physician: To the best o	. (Specify)	irm, street, factory, office	mo data and place	City or Town		
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	Medical	(Check only one)  29b. Signature and title of Fertifier	examiner: On the basis of and manner sta	examination an ted.	d/or investigation, in my o	pinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)
6	1200		30. Name and address of person v	who completed cause of de	eath (Item 23a)	(Type, Print)	20081	0 0	amay	14 H2004
8	Sta Regist		SUZAN / Day, Year)  JAN 2 0		2005 r's Signature	Signal la			want	201029

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ROLAND OLIVER BRUSCUP JANUARY 21, 2004 11:00 A<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTREVILLE OUEEN ANNE'S CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Hours **Funeral** Months 1**X**M 2□ F Yrs MARYLAND Director 212-01-3903 MAR. 9, 1916 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral, or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 🗑 No QUEEN ANNE'S CHESTER MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21619 1415 OUEEN ANNE'S DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 Divorced Year or Dates "natural" Completed event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROJECTIONIST MOTION PICTURE 11 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked LEILA JOHNSON ROLAND BRUSCUP ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 QUEEN ANNE'S DRIVE, CHESTER, MD MYRTLE BRUSCUP/WIFE 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY 01/26/2004 STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS. HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK RD., CHESTER, MD 21619 21. Signature of Funeral Service Licensee HOME, P.A. 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one caus Approximate Interval Between Onset and Death cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Ischemic Carliomygrathy Immediate Cause (Final disease or condition N Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ 3 ☐ Probably 4 🖼 nknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 rsing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ≥ No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Anatural м 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 192 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and rile of centifie 30. Name and address of person with completed cause of death (Item 23a) III pe, Print) make Drive Charle, MD 21619 210 06-7 Dr W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

-	. 7	-	For State AMENDED 10c,	State of Mary	vland/[ B,DOR	Departme <i>Certifica</i>	nt of H <i>te of l</i>	lealth Death	and Me		giene Reg. No. 2	2004	04366
			Decedent's Name (First, Middle, Last)							2. Date of Dea	ath		3. Time of Death
	Physicia			adv Henr	v Rı	radfor	4		J	ANUARY	23,	2004	06:50P M
	/Medica	_	4a. Facility Name (If not institution, give s		y D.		, Town, or	Location			<del></del>	ounty of Death	
1	Examine	r			704						CEC	ידד	
			VA MARYLAND HEALTH  5. Social Security Number 6. Sex		יויב n yrs. last bii		RY PO		r 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
8	Funeral Director	ĺ		<sup>™ 2□F</sup> 78	-	Yrs. Months	Days	Hours	Min.	Month, Day	y, Yea <i>r)</i> 30 192		vland
BRADFORD	Director	-	Usual Residence of Decedent	70						.pr.i.	,0,152		<u> </u>
<u>A</u>	land		10a. State 10b. County	10	c. City, Tow	n or Location							10d. Inside City Limits
器	Maryland f show	ō	Maryland Dorcheste	er	- 5	428 Whi	te Ha	ill R	oad (	Cambrio	dae		1 Yes 2 No
CK	18 ag	e c	10e. Street and Number			10f. Z	ip Code					n of What Cou	ntry?
HENRY X	3a or	<u> </u>	5428 White Hall Ro	ad			2161	3				US	
田光	death ms 23	by Funeral Director	11. Marital Status	2. Was Decedent Eve	r in U.S.	13. Was Dec	edent of H	ispanic O	rigin? (Spec	cify Yes or No-	- 14.	Race - Amen	
X (0	or iter	Ē	1 Never Married 2 Married	Armed Forces? 1 No Yes 2 No	1943			Specify		iican, etc.)			ite
BRADY -0036	urs a	۵	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1964	1 LI Tes	2 No	<i>эрөспу</i>	•		3,	респу.	
BRAD) 5-0036	72 hours 'naturel', dical Exe	Completed	15. Decedent's Educ (Specify only highest grade		16a	. Decedent's Us	ual Occup	ation during mo	st of workin	a	16b. Kind	of Business/Ir	ndustry
∺ <del>Z</del>	within 7 ene. then "r	pie	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of v life. DO NOT	use retired	1)					
IA 21:	d wild will	ĕ	7			<u>US Air</u>	For						y Service
PHYSICIAN <b>aryland 212</b>	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Maiden Su	urname)	
YS 1 <b>a</b>	ould b I Menta	2	William Henry Brad	dford				and the same of the same of		Thomas_			
	2 shoul and M is marl eumati		19a. Informant's Name/Relationship (Ty)	oe, Print)	198	o. Mailing Addre	ss (Street	and Numb	per or Rural	Route Number	er, City or T	Town, State, Zi	p Code)
o ≥	and 2 lealth a m 27 is		Doris T. Bradford	Wife		5428 Wh		Tall :		-			
Je J	-10-		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ R	1	cemete	of Disposition (N ery, crematory of	other plac			ate		ition - City or T	
KNOWN T	Pages nent of ant: If it ary or o		'4 □Donation 5 □ Other (Specify)	emovariiom state	Dorch	ester M	em. I	Park	1/28,	/04	Camk	oridge,	Maryland
₹ <b>=</b>	4 E E E		21. Signature of Funeral Service License	96	-	22. Name	and Addre	ss of Faci	lity Home	e, P.A.			
<b>m</b>	Department Impo		Brie k. Bu							21613			
NAME B			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	e death. Do	not enter the m	ode of dyir	ng, such a	s cardiac or	respiratory a	rrest,		Approximate Interval Between
	Pile interior		Immediate Cause (Final				<b>a</b> n					1	Onset and Death
	Physician   /Medical		disease or condition resulting in death)	Due to (or as a c			SE						UNKNOWN
	Examiner			_ALZHEIMEI									IINKNOWN
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c									OTMICTACONIA
	cate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events										
Ć.	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a c	onsequence	of):							
8760,	e be /sicia e bur	dicai	U.	1									
.89	ificat g phy as the	edi											
Вох	leath certifica attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of 1 ☐ Live birth 2 [		h 3⊟Ectopic	programs	,			23	d. Date of deli-	
ă	d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at tim		5 ☐ Other						Month	Day Year
0	the cy the ache	hys	9 🗆 Unknown	9□ Unknown						_			
٦.	Physician: The law requires that the death certificate has been signed by the attending profile director, page 2 should be detached for use as	by P	Part II. Other significant conditions con	ntributing to death but r	not resulting	in the underlying	g cause giv	en in Pad	H.	23e. Did t	obacco use		the cause of death?
g	n sig	d b								10	Yes 2□	No 3□Pro	bably 4 Xunknown
<u> </u>	w require been signature	iete								24a. Was	an	24b. Were au	opsy findings available ompletion of cause of
Re	The law ate has page 2 :	Completed		-						autor perfo	rmed?	death?	2□No
70	ician: Th	ပိ	25. Was case referred to medical					26 Pla	ce of Death	(Check only o		1 103	2010
₹	ysician: is certific director,	8	avaminar?	lospital:	2 🗆 ER/O	outpatient 3	DOA Ott					☐Other (Spec	ifv)
of		: To	27. Manner of Death	28a. Date of injury	28b.	Time of	28c. Inju	ry at	-	8d. Describe			7,
on	ding Phy h. After thi funeral	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear)	Injury M	W₀ 1 □	rk? ]Yes 2[	□No				
<u>:S</u>	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home,	farm, street, fact	ory, office		2	28f. Location (	Street and	Number or Ru	ral Route Number,
Division of Vital Records,	F 9 F C	Certification:	4 Homicide	building, etc. (	(эрөсіту)					City or To	mii, Gialle)		
	Hospital 4 hours a Funerel tely filled		29a. Certifier 12 Certifying Phy	sician: To the best of i	my knowledg	ge, death occurr	ed at the ti	me, date a	and place, a	and due to the	cause(s) a	nd manner as	stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medicai	(Check only 2 Medical Exami	ner: On the basis of ex and manner state	xamination a d.	ind/or investigati	on, in my	opinion, de	eath occurre	ed at the time,	date and p	place, and due	to the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and title of certifier			1	29c. Licen	se numbe	r		29d. Date	signed (Month	, Day, Year)
	F > F 0		> 1_1 11_	1			D5273	39			.ΤΔΝΙΙΔ	ARY 23,	2004
			30. Name and address of person who co	ompleted cause of dea	th (Item 23a		JJE1 -				J. 110F	/	
			SURESH SHANDELYA,				H CAI	RE SY	STEM,	PERRY	POIN	Γ, MD	21902
	Sta	te	31. Date filed (Month, Day, Year)	92 Bogistro	Signature	An I	0 0	,					
	Registr		Jan 2	0 200	Digital States	JO M	1						

			1 - For State Registrar	State of Maryla		artment of H <i>rtificate of L</i>			ene 20	04 0436
	Physic	ian	Decedent's Name (First, Middle, Last					2. Date of Death Month		3. Time of Death
X.	/Medi Examir		Albert S 4a. Facility Name (If not institution, give	tewart But] street and number)	ler	4b. City, Town, or	Location of Death	January	20,2204 4c. County of	
	Funeral Director		Chestertown Nur 5. Social Security Number 6. Se	sing & Rehab, x XM 2□F 7. Age (In yrs	Cente Last birthday) Yrs.	r Cheste If Under 1 Year Months Days	rtown If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		Birthplece (State or Foreig Country)
	ŋ		220-28-0784  Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	ocation		June 19	,1932	Maryland  10d. Inside City Limits
	ith the Maryk or 28a-f sho	Director	Maryland Kent  10e. Street and Number		Rock			100	. Citizen of Wh	1 ☐ Yes 2 28 No
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Mudical Examiner must be notilised at	by Funeral Director	22018 Lovers  11. Marital Status  1 Nover Married 2 Married 3 Widowed 4 Divorced	Lane  12. Was Decedent Ever in I Armed Forces?  1 □ Yes 2 Ø/No If Yes, Give Year or Dates:		2166 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 20 No	spanic Origin? (St	pecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
21215-0036	d within 72 hou giene. er then "neture" in Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	(cation (e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired ter Shac	luring most of worl )	sing 16	Seafo	ness/Industry
Maryland	nould be file d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last)  Thomas Bruce	Butler			18. Mother's Nam Anna	e (First, Middle, Ma	iden Sumame) t	*******
Baltimore, Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at ONCE.		19a. Informant's Name/Relationship (T)  Myrtle Butler  20a. Method of Disposition  1 ○ Burial 2 □ Cremation 3 □ II  4 □ Donation 5 □ Other (Specify,	/ Sister 20b.	220 Place of Dispo cemetery, cre-	18 Lovers sition (Name of matory or other place)	Ln Ro	ck Hall M Date 20	aryland	
Balti	permit. Departm Importa sny inju		21. Signature of Funer Privice Licent	unce .	2:	Name and Address Bennie Road 298	s of Facility mith Fund , Chester	eral Home rtown,Mar	yland 2	
	Physician /Medical		23a. Patt. Enter the disease, or comp show, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	S Cor	ter the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onser and Death
8760,	cate be executed physician and ithe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fursease or injury that initiated events resulting in death) Last	b. Due to (or as a conse						
O. Box 68	death certiff e attending d for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 \( \_\text{Live birth} \) 2 \( \) Fet 4 \( \) Pregnant at time of 9 \( \) Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
1	The law requires that the ate has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	and the second	in in Part I.			ute to the cause of death?  Probably 4 onknown
Vital Records,		Completed		,				24a. Was an autopsy performe 1 □ Yes 2 ☑	d) prio	re autopsy findings available or to completion of ause of th? Yes 2 No
ö	ding Phys h. After this funeral di	tlon: To Be	25. Was case referred to medical examiner?  1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	or: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how		(Specify)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, sti lify)	eet, factory, office		28f. Location (Stree City or Town, S		or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat lation and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	se(s) and manne and place, and	er as stated. I due to the cause(s)
r	To to withi To to	ž	29b Signature and title of cyrtifier	Jon		29c. License	number			Month, Day, Year)
			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	1000	Rd	CBE	8 Fan	9-2004 or Ad 7/14
送を	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign		holes	, 10 10 10			

Please	Type or	Print in	Black In	ndelible Ink.	<b>Ensure All</b>	Copies	Are Legible
	3 1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 1502 2004 Bernard Wayne Blake January 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EQ5100 If Under 1 Year at Easton 121601 Marylana Memorial HOSPITA If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 10 M 2□F Director 214-70-6618 48 19,1955 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or Itams 23a or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Talbot 0xford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5470 OFord 21654 Road USA tiled within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify. þ 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be tiled w Department of Health and Mental Hygien Important: If Itam 27 is merked other it eny injury or other traumatic event, Ita one. Dish Washer Restraunt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Edward Barbara Davidson Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffery Blake / Brother 4605 Calvert Road, college Park,Md. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 □Donation 5 □ Other (Specify) Flamers Cemetery 01/31/2004 Easton, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 21. Signature of Funeral Service Lice nuce 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** PNEUMONIA MONTH /Medical Due to (or as a consequence of). Examiner D UNKNOWN Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has tirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be within 24 hours atter de To tha Funaral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Florin D0028808 01/22/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Florin Rusu MD 219 S. Washington Street, Easton, Maryland 21601 31. Date filed (Month, Day, Year) ----32 Registrar's Signature State JAN 3 0 2004 Registrar

		For State Registrar	State of Maryland /	Department of He			ene a. No. 2004	0436
Physicia	an	1. Decedent's Name (First, Middle, Las	ot)			2. Date of Death Month		3. Time of Death
/Medic	al	Dianne Reba B  4a. Facility Name (If not institution, give		4b. City, Town, or	Location of Dogth	January	17 2004 4c. County of Deeth	7:28 A M
Examin	er	Prince George's			everly		Prince G	enrae!s
Funeral Director		5. Social Security Number 6. So			J	8. Date of Birth (Month, Day, Nov. 30	Year) 9. Birthp	place (State or Foreign htry) York
pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	on or Location				0d. Inside City Limits
Maryla f eho	tor		e George's		W11			1 □XYes 2 □ No
h the	Director	Maryland Princ  10e. Street and Number	e George s	10f. Zip Code	er Marlbo		g. Citizen of What Cour	ntry?
23a c		4352 Swindon	Terrace		20772		United	States
IOCE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. It ferm 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1	
5-0 72 ho	eted	15. Decedent's Ed (Specify only highest gra		. Decedent's Usual Occupa (Give kind of work done do	uring most of workli	79	6b. Kind of Business/In	dustry
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)				
d 2 filed Hygie Sther ant, u		17. Father's Name (First, Middle, Last)	2	ccounting Ad	ministrat 18. Mother's Name		Priva Biden Sumame)	te
faryland	To Be	Thomas Bell				Mary Oth	nelia Bass	
laryla 2 should and Men is marke aumatic		19a. Informant's Name/Relationship (7		. Mailing Address (Street a	nd Number or Rura	Route Number,	City or Town, State, Zip	Code)
and and lealth m 27		Inshirah Bell - 1		4352 Swindon				20772
Baltimore, permit. Pages 1 ar Department of Hea mportant: if tiem nny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State cemete	of Disposition (Name of try, crematory or other place	)		Oc. Location - City or To	
Baltimo	i	<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signalure of Funeral Service Licen</li> </ul>		Hill Cemete			Suitland, Suneral Hom	
Depa Impo Impo Impo		John T. S	Town X III		, ,		ish., DC 20	
Pnysician	0 1	23a. Pert 1 Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or andition	plications that caused the death. Do one cause on each line.  META STATI (	not enter the mode of dying		r respiratory arres		Approximate Interval Between Onset and Death
ecords, P.O. Box 68760, law requires that the dear or criticate be executed as been signed by the att. noting physician and 2 should be detached to use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c.  Due to (or as a consequence d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	of):  3 □Ectopic pregnancy			23d. Date of delive	ory Day Year
O. E. ne dea	sici	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			Month	Day Year
IS, P.O.		Part II. Other significant conditions of	ontributing to death but not resulting i	n the underlying cause giver	n in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
rds, tuires	d by	Responding	Insufficiery			1 ☐ Yes	2 □ No 3 □ Prob	ably 4 🕅 Unknown
W 0 - 8	Completed	<u> </u>				24a. Was an autopsy performe	prior to cor ed? death?	osy findings available inpletion of cause of
of Vital F Physician: Th ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitali	0	26. Place of Death	(Check only one)		
Of \Physical Physical this control and direct this control this contro	1	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2X ER/Out 28a. Date of Injury 28b.	The same of the same of	4   Nursing Hon		ce 6 Other (Specify	)
Division of the Hospital or Attending Phoshin 24 hours alter death. To the Funeral Director: Atter the completely tilled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury Work? M 1 □ Yo	es 2□No	8d. Describe how		
Division Ital or Attenurs atter death ral Director:	Certif	4 Homicide determined	building, etc. (Specify)			City or Town,		
To the Hospital  You the Hospital  To the Funeral I  completely tilled	edicai	29a. Certifier (Check only one)  1 Certifying Physical Example (Check only one)	ysician: To the best of my knowledg liner: On the basis of examination ar and manner stated.	e, death occurred at the time ad/or investigation, in my opi	e, date and place, a inion, death occurre	nd due to the cau d at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)
T to the complete com	₩.	29b. Signature and title of certifier	1 2 -1	29c. License			I. Date signed (Month, I	
((10)		> K. Mer	huel Jega	20.	052865	J	ANJARY 1-	1th 2004
0		30. Name and address of person who o	e 4D 3ael	(Type, Print)  4 HISH TIME D	RIVE	CHEVER	RLY, MD a	20185
Sta Registr		JAN 2 7 2004	32. Registrar's Signature					
DHMH 17 Rev 1/20		2 2004	ben to food					
			OR	IGINAL				

			1 - For State Registrar	State of Maryland /	Depa		of H	ealth a	nd Mental		ne	
	Physici	an	Decedent's Name (First, Middle, Last						2. Date	n [	Day Yea	3. Time of Death
	/Medi	cal	Adalene Marteno  4a. Facility Name (If not institution, give							ary 2	7, 2004	8:30 a.m
4	Examir	er	5 Letterman Court					Location of Sburg			4c. County of De	
	Funeral		5. Social Security Number 6. Se:	x 7. Age (In yrs. last i	oirthday)	If Under 1		If Under 2		of Birth	Montgom 9.B	
A	Director		116-07-1286	□M 2\\ F 93	Yrs.	Months	Days	Hours	Min. (Mont. 2/1:	of Birth h, Day, Yea 3 / 1910	o Wes	lirthplace (State or Foreign Country) St Virginia
	pu 🛌		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	um or la							
	Aaryla r shor	ō										10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Montgome:  10e. Street and Number	ry Gaith	ersl	ourg 10f. Zip (	`ode			100 (	Citizen of What (	
	h with		5 Letterman Court				 0878	)			S.A.	Southly ?
	deat	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13.				n? (Specify Yes o		14. Race - An	nencan Indian,
36	or its	y Fu	1 Never Married 2 Marned	1 ☐ Yes 2 🕅 No		i res, specii 1 □ Yes 2		Specify:	Pueno Rican, etc	.)	Specify:Wh	
Ö	be filed within 72 hours after death with the Maryland tast Hygiene. Id other than "naturel", or Itams 23a or 28a-f show ovent, I'ra Medical Evantiner must be routiled at	ed by	3 XWidowed 4 □ Divorced	Year or Dates:								
5.	in 72 n "na n "ealic	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	a. Deced (Give life.	dent's Usual kind of work DO NOT use	done di retired)	tion <i>uri</i> n <i>g most</i> d	of working	4	Kind of Busines	s/industry Agriculture
212	d within giene. r than "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		etary	, , , ,			0.5	· Dept.	Agriculture
ם	be filed ttat Hygi td other event, t	BeC	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Mi	ddle, Maide	en Sumame)	
yla	should be nd Mentat marked imatic ev	To	Denzil R. Marteney	7				Bessi	e L. Mal	colm		
Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be Department of Health and Menta important: If Item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Ty	rpe, Print)	b. Mailir	g Addrass (	Street a	nd Number	or Rural Route N	umber, City	or Town, State,	Zip Code)
e,	1 and Health em 27 ther t		Johanna M. Bellema 20a. Method of Disposition			terma		ourt,	Gaithers	-		
nor	ages nt of t: If it		1 X Burial 2 ☐ Cremation 3 ☐ R	comot	ery, cren	natory or oth	er place				Location - City o	West Virginia
Ħ	artme ortani injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	i_			Address					
B	Depa impo any ir		Claudette	Harch Hannin	47	39 Ba	1 t i m	ore A	Gasch's ve., Hya	Funer ttsvi	al Home	, P.A. 20781
3			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do							TTC, III	Approximate
Į,	Physician		Immediate Cause (Final disease or condition	Pneumonia								Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):							
	Examiner		Sequentially list conditions, b	. Coronary Arte		iseas	e					
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Undernin Cause (Disease or injury	Due to (or as a consequence		nosexu-						
	al-trar	Examiner	that initiated events resulting in death) Last	Cerebrovascul  Due to (or as a consequence		ccide	nt					
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	calE			,							
Ó	tificat ig phy as the							-				
Вох	that the death certific ed by the attending p detached for use as	by Physician/Med	200. Was decedent program	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3□	Ectopic preg					23d. Date of de	alivery
	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death		Other (spec				_	Month	Day Year
<u>Р</u>	that the	Phy	9 Unknown									
ds,	es ga		Part II. Other significant conditions con	tributing to death but not restiting	in the un	derlying cau	se giver	in Part I.				o the cause of death?
Records,	w requir been si should	Completed							_	:		robably 4 🖾 Unknown
Re	ne lav s has ge 2	mp							a	Vas an utopsy erformed?	24b. Were a prior to death?	utopsy findings available completion of cause of
g	ician: Th certificate rector, pag	မ ပိ	25. Was case referred to medical						1 □ Ye	s 2MN	o 1 Yes	s 2 No
>		OB	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/O	utnatient	3□ DOA	Other		Death (Check or		6 COther (C-)	
0	문 후 교	L iu	27. Manner of Death	28a. Date of Injury 28b.	Time of		. Injury a	it			ury occurred	эспу)
Ois	Attending I r death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day You)	Injury	М	Work? ↑ □ Ye	s 2 No				
		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, factory, o	ffice		28f. Location	n (Street a Town, Stai	and Number or R	ural Route Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in		20a Cartillar 4 M Cartillar 2								,	
		edical	29a. Certifier 1 ☒ Certifying Phys (Check only 2 ☐ Medical Examin one)	ician: To the best of my knowledg ier: On the basis of examination at and manner stated.	e, death nd/or inv	occurred at estigation, in	the time my opir	, date and p nion, death o	lace, and due to occurred at the tir	the cause(: ne, date ar	s) and manner a: nd place, and due	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. L	icense r	number		29d. Da	ate signed (Mont	th, Day, Year)
}	1		> a Leidman	n MN			D37	801			uary 28	
)	12)		30. Name and address of person who con	mpleted cause of death (Item 23a)	(Туре, Е	Print)					,	
			Aimee Seidman, M.D	., 11906G Darnes	tow	n Road	l, N	. Pot	omac, MD	208	78	
as.	Star Registra	_	31. Date filed (Month, Day, Year)  JAN 2 9 2004	22. Registrar's Signature	bad	W.						

		1- State 1-29-04 Registrer Amend #23a.P	rt.1.Per	of Marylaı <u>Phys.PGC</u>	nd / Dep cr <i>Ce</i>	artment of rtificate o		nd Mental Hy	Reg. No.	2004	0437
Physici		Decedent's Name (First, Middle, L	_ast)	NNETT				2. Date of D Month <b>JAN</b> .	Day 26	2004	3. Time of Death  10:45A M
/Medic Examir		4a. Facility Name (If not institution, g	ive street and no	umber)		4b. City, Town	n, or Location of (			ounty of Death	
Exami		FOX CHASE REHA	B & NU	RSING	CTR.	SILV	ER SPR	ING	MO	ONTGOM	ERY
Funeral Director		247-36-5955	Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs <b>80</b>	. last birthday) Yrs.	If Under 1 Ye Months Day		Hrs. 8. Date of B (Month, D 1 - 18	ay, Ye <i>ar)</i>	Cou	place (State or Foreign ntry) <b>Virgin</b> i
fand ow		Usual Residence of Decedent  10a. State  10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Mary a-f sh	ţċ	D.C. N/A		W	ashin	gton					1 <b>X</b> Yes 2 ☐ No
ith the	Director	10e. Street and Number				10f. Zip Cod				n of What Cou	ntry?
ath w	rai	4824 Fort					011			S.A.	
within 72 hours after death with the Maryland ane. than 'natural', or Itams 23a or 28a-f show ta Madical Examirer must be natified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	cedent Ever in torces? 2 No ive				? (Specify Yes or N Puerto Rican, etc.)		. Race - Americ Black, White,	etc.
ours a	þ	3 Widowed 4 □ Divorced	If Yes, G Year or I	ive <sup>2</sup> Dates:		1 □ Yes XX	No Specify:		s	pecify: B1	ack
72 h	etec	15. Decedent's (Specify only highest g		)	16a. Dece (Give	dent's Usual Oc kind of work do	cupation ne during most of ired)	f working	16b. Kind	of Business/In	ndustry
within ene. than	Completed	Elementary/Secondary (0-12) 8th	College	(1-4or 5+)	1	nt. Wo			Pub]	lic Sc	hools
illed Hygie othar ant, II	BeC	17. Father's Name (First, Middle, Las					18. Mother's	Name (First, Middle	, Maiden Si	umame)	
should be nd Mental markad c	To B	Not A	vailab!	le			E	mma Bool	cer		
ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avent, it is Marical Examiner must be nailified at		19a. Informant's Name/Relationship Willie C. Be		Son							Code) 20721 lle, Md.
Pages 1 a nent of Hea int: If itam iry or otha		20a. Method of Disposition  Burial 2 Cremation 3	☐Removal from	State	cemetery, cra	sition (Name of matory or other p	olace)	Date 1/31/04		ndover	
permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Spec 21. Signature of uneral Service Lic		/		2. Name and Ad	dress of Facility				•
9 9 E 18 9		In elta	W. Ha	rcket >	Gr.	наске 814-	tt's Fi Unshur	uneral C	nape. N.W	l, Inc	
nysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	iv one cause on	each line.				Insuf			Approximate Interval Between Onset and Death
The law requires that the death certificate be executed X the has been signed by the attending physician and age 2 should be detached for use as the burial-transit of	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		rdial quence of):	Infarct					
inat the death certific hed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ★No 9 □ Unknown	1 ☐ Live	utcome of pregn birth 2 Feta nant at time of a nown	al death 3	Ectopic pregna Other (specify)			236	d. Date of delive Month	ery Day Year
ures that signed b Id be deta	by	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		tobacco use		he cause of death?
	Completed							24a. Was auto perf 1 🗆 Yes		24b. Were auto prior to co death? 1  Yes	psy findings available impletion of cause of
ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				2thor	Death (Check only			
Phys rthis raldir	L.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatier 28b. Time o	I SI DOA	Other: 4 <b>X</b> Nursii jury at	ng Home 5 Res			y)
Attanding Physician: r death. sctor: After this certifica by the funeral director.	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Moi	nth, Day Year)	Injury	V	Vork? □Yes 2□No	200. 5000.00			
i i i i	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 288. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, str fy)	eet, factory, offic	<b>28</b>	28f. Location ( City or To		Number or Rura	al Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ex-	aminer: On the t	e best of my kno casis of examina oner stated.	owledge, deat ation and/or in	n occurred at the vestigation, in m	time, date and p y opinion, death o	place, and due to the occurred at the time,	cause(s) ar date and pl	nd manner as si ace, and due to	tated. the cause(s)
Vithin To tha	Me	29b. Signature and title of certifier			_	29c. Lice	nse number		29d. Date s	signed (Month,	Day, Year)
		) CE	1/2	2	MD	M	0585	97	01/	281	04
(7)		30. Name and address of person who	o completed cau	_	т 23а) (Туре,	Print) 860	09 21d	Ave , sui		4048	, , ,
	v	31. Date filed (Month, Day, Year)		Registrar's Sign		J 111	- C 3/11/	1.000	110		

0.2		ŀ	For State Registrar	State of Ma	aryland / De	partment ertificate			nd Me		ene 3. No.2	004	04372
(co	Physici		Decedent's Name (First, Middle, L.  Thomas	ast)	Barbo	our				Date of Death Month anuary	Day 16	2004	3. Time of Death 3:01p M
>	/Medio Examin		4a. Facility Name (If not institution, gi	ive street and number)		4b. City, T	Town, or L	ocation of D	Death	<del>_</del> _	4c. Cou	unty of Death	
			The John Hopki					ore C					
	Funeral Director		5. Social Security Number 6. 577-90-3885  Usual Residence of Decedent	Sex 7. Age 12X M 2 □ F	32 Yrs	Months	Days	Hours N	Min.	Date of Birth (Month, Day, 5 – 22 – 7	(ear)	Coun	place (State or Foreign ntry) ningtonDC
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ta Madical Examiner must be nuffied at	tor	10a. State 10b. County	Georges	10c. City, Town or Suitla							1	0d. Inside City Limits  X☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number	Pood And	- 204	10f. Zip (	746				g. Citizen USA	of What Coun	itry?
	d within 72 hours after death with the Marylan joine. r than "natural", or Itams 23a or 28a-f show the Madical Examiner rust be nulffed at	Funeral Director	3807 Swann  11. Marital Status  1 Never Married 2 Married	12. Was Decedent 8 Armed Forces? 1 □ Yes 2 🕅	ever in U.S. 1	3. Was Decede If Yes, speci	ent of Hisp	panic Origin' Mexican, P	? (Specification Rice	y Yes or No-	14.1	Race - Americ Black, White,	etc.
-003	tural, or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	16a. De	1 Tes 2	Occupati	Specify:		110		ecify: b1	Lack
21215-0036	d within 72 piene. r than "na Ir e Medic	Completed	(Specify only highest gi	rade completed)  College (1-4or 5 1 +	(G	ive kind of work DO NOT use Truck	k done du e retired)	ring most of	f working				ervice
Maryland 3	al Hyg	To Be C	17. Father's Name (First, Middle, Las Thomas Barbot				1			First, Middle, Ma e Wats		name)	
	d 2 sho th and ! 7 is me traume		19a. Informant's Name/Relationship Dawn L. Barbon							oute Number, o u <b>i</b> tlar			
Baltimore,	m 0		20a. Method of Disposition  1  Burial 2  Cremation 3 (  4  Donation 5 Other (Spec	☐Removal from State	20b. Place of Dis cemetery, of Riverda	sposition (Namerematory or other	e of her place)		Date	20	c. Location	on - City or To	own, State
Balti	permit. Page Department Important: any injury once.		21. Signature of Funeral Service Lice		hu	22. Name and	Address	of Facility		l Chap Washin			20002
	Enysician :		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	y one cause on each lin	е. 🗸	enter the mode	of dying,	such as car	rdiac or re				Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	erstitia a consequence of): te Renal			seas	е			1	0 months 2 days
7.5	ed	Examiner	Sequentially list conditions, in y cause. Enter Underlying Cause (Disease or injury	D	consequence of):	. raii	ui e						Z days
8760,	ate be executed obysician and the burial-transit	cal	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):								200
.O. Box 6	that the death certificat hed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death	3 □Ectopic pre 5 □ Other (spe						Date of deliver Month	ory Day Year
<u>α</u>	w requires that been signed by should be deta	þ	Part II. Other significant conditions	contributing to death bu	at not resulting in the	underlying ca	use given	in Part I.					ne cause of death? ably 4 □Unknown
of Vital Records,	The law ate has b page 2 s	Completed							_	24a. Was an autopsy performe		death?	psy findings available inpletion of cause of
Vita	Physician: This certificatral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Othor			heck only one)			
of \	Phys rthis raldii	n: To	1 ☐ Yes 2 ★No  27. Manner of Death	Hospital: 1 ☒ Inpatie  28a. Date of Injur (Month, Day			c. Injury a Work?	4 U NUISIN		5 🗌 Residen I. Describe how			)
Division	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determined	be Osa Blace of Init	ırv - At home, farm.	М	1 □ Ye	s 2 No	281.	Location (Stre	et and Nu State)	mber or Rural	l Route Number,
Ō	spital o		29a. Certifier 1X Certifying P	hysician: To the best of		eath occurred a	t the time.	date and pl	lace, and	due to the cau	se(s) and	manner as sta	ated.
	tha Ho hin 24 h tha Fui npletely	Medical	(Check only 2 Medical Exa	aminer: On the basis of and manner sta	examination and/or	investigation, i	License r	nion, death o	occurred a	at the time, date	and plac	e, and due to	the cause(s)
	T wit	-	29b eignature and title of goutfler	M.D.					0			y 16,	
-1	3)		30. Name and address of person who Amar Krishnasw		eath (Item 23a) (Type) North		Str	eet,	Ba	1timo	ce,	MD 21	287
	Sta Registr		31. Date liled (Month, Day, Year)  JAN 3 0 2004	32. Registra	r's Signature								

RY	BROWN	•	For State Registrar	State of Mary	•	artmen ertificat					Reg. No. 2	004	04	373
>	Physicia /Medic Examin	al .	Decedent's Name (First, Middle, Last     MARY  4e. Fecility Name (# not institution, give	street and number)	BROWN			Location o	f Death	2. Date of De, Month JAN.	11, 20	O4  Aty of Deeth		of Death
2	Funeral Director		3/7-96-1018		yrs. last birthday 56 Yrs.			If Under a		8. Date of Bird (Month, Da 11-29			place (State	or Foreign
Maryland 21215-0036	iled within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show nt, the Madical Examiner must be multiled at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD PRINCE (  10e. Street and Number  2622 KIRKWOOI  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grade)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  HARRY	DEORGES  PLACE, #  12. Was Decedent Ever Armed Forcas? 1 □ Yes 2 ② No If Yes, Give Year or Dates:	HYATTS  4301 r in U.S. 13	VILLE 10f. Zip	Code  207  dent of Hicry Cuba  2X No  al Occupark done of se retired	spanic Oric n, Mexican Specify: ation turing most Y E D	gin? (Spe , Pueno F t of workin	cify Yes or No lican, etc.)	10g. Citizen o  U •  14. R B Spect	of What Cour S . A . ace - Americ lack, White, city: B L A	0d. Inside 0 1 (XYes	s 2□No
Baltimore, Maryl	permit. Pages 1 and 2 should be in Department of Health and Mental I important: if Item 27 is marked of any injury or other traumatic eve once.		19a. Informant's Name/Relationship (7 GERTRUDE EVANS  20a. Method of Disposition  1 Disposition  2 Cremation 3 Cherry (Specify  21. Signature of Funeral Serves Light	- SISTER  Removal from State	26. Place of Disposementary, critical MT . ZII	22 KI costion (Narelematory or of ON CE	RKW	OOD  ERY s of Facilit	PL.,  Date  2-2-  y TA	#301 ate 2004 .YLOR'	HYAT' 20c. Location BALTII S FUN.	TSVIL n - City or To MORE, ERAL	LE, Dwn, State  MD HOME	20782 MD 001
760,	Physician /Medical Examiner a pruial-trausit	cal Examiner	23a. Pert1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	ve arter	rioscl	erot	ic ca	rdio	vascula	ar dise	ase	Approxima Interval Be Onset and	ite itween Death
.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as tha burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pi □ Other (sp						Date of delive	ery Day	Year
Records, P.	requires been sign	Completed by P	Part II. Other significant conditions on Chronic alcohol		ot resulting in the	underlying o	cause give	en in Part I.		1 🗀 Y	psy ormed?	3 Prob	pably 4	Unknown s available
Division of Vital	ling Physician: 1. After this certifice funeral director, f	Medical Certification; To Be C	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Ye Found: 1-11	L=04 Unk - At home, farm, s Specify)	of 2	28c. Injury Work 1 🔲 '	er: 4 □ Nu	No 1	Check only of the 5 Resident R	dence 6 00 how injury occ	Other (Specification of the Control	viron	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only 2 Medicel Example)  29b. Signature and title of certifier  30. Name and address of person who	ysician: To the best of miner: On the basis of example and marker stated	ny knowledge, de amination and/or	290 290 9, Print)	c. License	number M.E	d place, a th occurre	and due to the	cause(s) and date and place 29d. Date signal JAN.	manGCOL e, and due to ned (Month, 11,	is S the cause	Co.,M
V	Sta Registr		JARON LOCK 31. Date filed (Month, Day, Year) JAN 3 0 2004	32. Registrar's	Signature		eet,	Balt	imor	e, Mary	yland 2	21201	-	

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland	•	artment of tificate of		and Mer		ene 2 () ()	4 04374
	-		Decedent's Name (First, Middle, Last)						Date of Death		3. Time of Death
	Physicia		Richard L. E	Baker				1 _	an. 1	7, 2004	
	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town,	or Location o			4c. County of D	
	Lxamiii	CI	Crescent City H	Mealthcare (	Cente	r Riv	verda]	le		P.G	•
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day,	(9.1	Birthplace (State or Foreign Country)
	Director		301-34-9897 <sup>103</sup>	t <sup>M 2□F</sup> 6	3 Yrs.	Months Days	110013	D D	ec.15	, 1940	Ohio
	Du ≽		Usual Residence of Decedent  10a, State 10b, County	10c City	, Town or Lo	cation					10d. fnside City Limits
	shov	5	Md. P.G.		Suit1						1 ☑ Yes 2 ☐ No
	he N	Director	10e. Street and Number		Julul	10f. Zip Code			100	g. Citizen of What	Country?
	with t	늅	3403 Navy Day D	rivo		Tol. Zip Code	20746	5		United	
	eath	Funerai		12. Was Decedent Ever in U.	S. 13.1	Was Decedent of	Hispanic Orio	gin? (Specify	Yes or No-	,	merican Indian,
	iner d	들	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □XYes 2 □ No	1	f Yes, specify Cu	ban, Mexican	, Puerto Ric	an, etc.)	Black, W	/hite, etc.
3	urs a		3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2DXNo	Specify:			Specify: B	lack
21215-0036	be filed within 72 hours after death with the Maryland the Hydjene. All the Western of other than "natural", or ferms 23a or 28a-f show do other than "natural", or ferm avert, the Medical Examiner must be notified at event, the Medical Examiner must be notified at	Completed by	15. Decedent's Educ		16a. Dece	dent's Usual Occu	upation	t of working	10	6b. Kind of Busine	
212	e. an "r	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retir		or working			
7	od wil	00	12		<u>I</u>	Inginee				Metro	
Maryland	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)							aiden Sumame)	
<u> </u>		္	Willie Everet						Clemo		
<u>a</u>	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Stree 1 Astor ≥igh, N	iand Numbe ia Pl	r or Rural Re	bute Number, (	City or Town, State	e, Zip Code)
	ss 1 and 3 of Health item 27 r other tr		Troy Hunter/son  20a. Method of Disposition		Rale	eigh, N sition (Name of	I.C.	2761 Date		0c. Location - City	or Town State
Baltimore,	Pages nent of h int: If ite	1	1 Burial 2 □ Cremation 3 □ R	emoval from State	emetery, crer	natory or other pl					
	it. Parturant		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funegaf Service License</li> </ul>	Md.		erans C	em •	1/26,	jes 🍇	Edward	ham, Md.
Ba	permit. Pages Department of Important: If it any injury or o		21. Signature of Pulletal Service License	dillands	/						,Md.20746
			23a. Pay1. Enter the disease, or compli	cations that caused the death							Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	^		_				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ		state w	11h	V/2 (Z	Stases		years
	Examiner			Due to tor as a consequ	ierice or).						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):		<u> </u>				
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
o	an an rial-tr	EX	resulting in death) Last	Due to (or as a consequ	ience of):						
8760,	cate be executed physician and the burial-transit	dical		l							
9		Med	IF FEMALE:								
. Box	death certifi e attending id for use as	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnan				23d. Date of Month	delivery Day Year
O	e des the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)				77.4	22, 732.
Δ.	that the death certif ned by the attending detached for use a	by Physician/Me	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause o	iven in Part I		23e. Did toba		e to the cause of death?
Š,	signe signe		Arnal failur				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Probably 4 □Unknown
Ö	w require been sig should b	Completed	1						04-146	045 144	
Sec	e law has l	mp	Chronoz 0837	ructive lus	39	Si Jeast			24a. Was an autopsy performe	prior	autopsy findings available to completion of cause of 1?
a	n: Th icate r, pag								1 ☐ Yes 20	ONo 1□Y	
₹	ysiclan: The la is certificate ha director, page 2	Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	lospital: 1 Inpatient 2	FD/Outti-	2000	thon		heck only one	) ce 6	
ō	r this	٦. آ	27. Manner of Death	28a. Date of Injury	28b. Time of	-				injury occurred	рөспу)
0	th. : Afte	ţi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ⊒Yes 2.⊟1	No			
Division of Vital Records,	al or Attending Physician: The law requires that the after death.  I Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2.	HC	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	Э	28f.	Location (Stre	et and Number or	Rural Route Number,
	s afte	Certification;	Tiomode	building, etc. (Opecity	/				ony or roun,	Oluley	
	To the Hospital or Attenwithin 24 hours after deating the Funeral Director; completely filled in by the	edicai (	29a. Certifier 1 Certifying Phys	sician: To the best of my knowner: On the basis of examinat	wledge, deatl	occurred at the	time, date and	d place, and	due to the cau	ise(s) and manner	as stated.
	To the H within 24 To the F complete	ledi	one)	and manner stated.							
	Viit To Con	Σ	29b. Signature and title of certifier	1 1.1.	10	29c. Licer	nse number	(1		d. Date signed (Mo	
7			Strull	NUM	w	4	216	) /-	J	anugry 1	7 6004
0	(5)		30. Name and address of person who co	mpleted cause of death (Item			/ 1 i =		אר בער	Y 727x	-,
	01		31. Date filed (Month, Day, Year)	22. Registrar's Signal	veen	22014 Lee	u my	4 1150	ne "	1	•
	Sta	itte	IAN 2 0 2004	E. L	1	100					

Continued of Deaths, 4-or Cofficiate of Death,		Please	State of Man				-	•	01075
SHIRLEY VIRGINIA COOK  SA Scaley have of three subdiction one some and an anatomal and accounts of the subdiction of the		4 State ()	5 per An As	S Cei	rtificate of D			2004	043/3
SSILITE TENDED TO SERVICE TO SERV	Dissolution		•		-	- 2			
Authority   Auth	/Medical	SHIRLEY VI	RGINIA CO	OOK					1352 M
2 Special policy of the control of t	Examiner	2 1 2.	/	1.1.1			1 4	, ,	108
Continued   Cont				LNTY			B Date of Birth	Q Right	
Too. State and Number 20 page 100. Conty Town of Location Seaford  100. State and Number 20 page 110. State and Number 20 page 110. State and Number 20 page 110. State and Number 20 page 110. State and Number 20 page 110. State and Number 20 page 110. State and Number 20 page 2	Funeral Director	222-18-3700A				Hours Min.	(Month, Day, Year	31 Mary	
Elimentary/isocratory (0-12)  College (1-407 5+)  School Bus Driver  Transportation  17. Father's Name (First, Moddle, Last)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  20. Moder's Name (First, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Name of Name of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name of Name (Pirst, Moder's Name of N	within 72 hours after death with the Maryland then "natural", or items 23e or 28a-1 show the Modical Examiner mant be notified at mopleted by Funeral Director	10a. State 10b. County		Oc. City, Town or Lo		ord			•
Elimentary/isocratory (0-12)  College (1-407 5+)  School Bus Driver  Transportation  17. Father's Name (First, Moddle, Last)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  20. Moder's Name (First, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Name of Name of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name of Name (Pirst, Moder's Name of N	3e or 28		ad			19973			-
Elimentary/isocratory (0-12)  College (1-407 5+)  School Bus Driver  Transportation  17. Father's Name (First, Moddle, Last)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  20. Moder's Name (First, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Name of Name of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name of Name (Pirst, Moder's Name of N	or Items 23e	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of His	panic Origin? (Spec , Mexican, Puerto Ri	ify Yes or No-		
Elimentary/isocratory (0-12)  College (1-407 5+)  School Bus Driver  Transportation  17. Father's Name (First, Moddle, Last)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  20. Moder's Name (First, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Name of Name of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name of Name (Pirst, Moder's Name of N	Examina I by Fu	3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☑No				,		
Elimentary/isocratory (0-12)  College (1-407 5+)  School Bus Driver  Transportation  17. Father's Name (First, Moddle, Last)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  17. Father's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  18. Moder's Name (First, Moddle, Macked Darbor)  20. Moder's Name (First, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Macked Namber of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name (Pirst, Moddle, Name of Name of Rural Route Namber, City or Town, State, 2p Code)  20. Moder's Name of Name of Name (Pirst, Moder's Name of N	alcal alcal	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	kind of work done du	iring most of working	16b. I	Kind of Business/In	dustry
17. Father's Name   Print, Modes   Author	ris marked other then " raumatic event, the Max To Be Comple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			nenorta	tion
205. Marched of Disposition - City or Town, State or Control Survived Control State - Colored	C H	17 Father's Name (First Middle   28)	*)	301100					
205. Marched of Disposition - City or Town, State or Control Survived Control State - Colored	Be e								ord
205. Marched of Disposition - City or Town, State or Control Survived Control State - Colored	To	19a Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street ar				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate and Death Testing in death)  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate and Death Testing in death)  Due to (or as a consequence of):  Due to (or	item 27 is r other trau			er 239	Crawford	d Drive,	Golden	CO 804	01
23a Part. Enter the idease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest.  Approximate shock, or heart failure. List only one cause on each ine.  Due to (or as a consequence of):	5			20b. Place of Dispo	sition (Name of matory or other place	Da	te 20c. L	ocation - City or To	own, State
23a Part. Enter the idease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest.  Approximate shock, or heart failure. List only one cause on each ine.  Due to (or as a consequence of):	5 -		□Removal from State  fy)	-	•		2004 Cok	esbury,	MD
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate and Death Testing in death)  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate and Death Testing in death)  Due to (or as a consequence of):  Due to (or	i i i	21. Signature of Funeral Service Lice	-	22	Name and Address	of Facility	111 - 37		
23a. Part I. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Immediate Cause (Final interval districts. List only one cause on each limit interval districts. Cause (Final interval	\$ a	Acloude		21	6 N. Mai	in St. F	nome, ra ederalsh	urg, MI	21632
Immediate Cause (Final continues of the continue of the cont		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not ent	er the mode of dying,	, such as cardiac or	respiratory arrest.		Interval Between
Sequentially list conditions, if any, leading to emmediate Cause (presence of the property of	sician	disease or condition	Myo	Cardial	-	farcis			
Sequentially ist conditions, risk add not present the cause. Enter Underlying the cause. Enter Underlying the cause. Enter Underlying the cause. Enter Underlying the cause is the cause of the cause	ledical aminer	resulting in death)	Due to (or as a c	onsequence of):					
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a	100	Sequentially list conditions,	b. Due to (or as a c	onsequence of):					
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a	nlne	cause. Enter Underlying	Due 10 (0) as a 0	onsequence or,					
FFEMALE:   23b. Was decodent pregnant in the past 12 months?   1   1   25   2   No   9   Unknown   2   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes   23c. If yes   23c. If yes, outcome of pregnancy   1   23c. If yes   23c. If yes   23c. If yes, outcome of pregnancy   1   23c. If yes   23c. If	Xar	Ulat Riflator events	c Due to (or as a c	onsequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   1	a		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	as the								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Onknown	an/M	23b. Was decedent pregnant			Ectopic pregnancy		10		•
Continue state   Continue   Con	hed for	1 ☐ Yes 2 ☐ No	4□Pregnant at tim					Month	Day Year
1   Yes 2   No 3   Probably 4   Unknown	Phy		contributing to don't but o	set reculting in the u	ndorhina oausa awar	o in Part I	23e Did tobacco	use contribute to t	he cause of death?
Section   Sect	p A	1 1 77:		iot resulting in the di	nobitying cause give	THE CITY			
25. Was case referred to medical examiner? 1   Yes   2   No    26. Place of Death (Check only one)  27. Manner of Death 1   Natural   2   28d. Describe how injury occurred  28d. Place of Injury at Work? 2   Accident   3   3   5   Pending investigation   3   5   Sending investigation   3   Suicide   4   Homicide   4   Homicide   28e. Place of Injury   At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Dey, Year)  30. Name an   ddress of person who completed cause of death (Item 23a) (Type, Print)  30. Name an   ddress of person who completed cause of death (Item 23a) (Type, Print)  31   Yes   2   No   26d. Place of Death (Check only one)  26b. Place of Death (Check only one)  27c. Place of Death (Check only one)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)	hould	Thirtie Fire	accirvo,				-		
25. Was case referred to medical examiner?  1   Yes 2   No	has been see 2 should mpleted	Thock Cive					autopsy	prior to co	mpletion of cause of
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred	S S		V 13/000	diag.				o 1 ☐ Yes	2 No
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred	After this certificate has funeral director, page 2 tlon; To Be Compl	examiner?	Hospital:	0□EB/Outpation	Other			S □Other (Specie	6.0
2   Accident 3   Suicide 4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)    29a. Certifier (Check only only only only only only only only	r this aral di		28a. Date of Injury	28b. Time of					<i>y</i> /
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2   Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)  30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)  30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)	tion the			ee <i>r)</i> Injury					
29a. Certifier (check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)  512	in by the	3 ☐ Suicide 6 ☐ Could not b	280. Flace of injury	- At home, farm, str Specify)	eet, factory, office	28			al Route Number,
30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)  GILG Trouth M.O. 100 E. CARROII ST. SALISBUM MO	ely fill	(Check only 2 Medical Exe	miner: On the basis of ex	amination and/or in					
30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print)  GILG Trouth M.O. 100 E. CARROII ST. SALISBUM MO	within 24 hours after death. To the Funeral Director: A completely filled in by the ti		and market states		29c. License	number	29d. Da	ate signed (Month,	Dey, Year)
	• 0	1200			Dan	CUITE	1	178/00	F
		30. Name an oddress of person who			Print)	378/9		, , , ,	
		file Trouth			ARROIL	51.	SA 6/56	Vag 1	ממ
	State	31. Date filed (Month, Day, Year)							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Josephine CONNOR 11 05 AM January 28. 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dennett Road Manor Nursing Home Garrett 0akland 8. Date of Birth (Month, Day, Mar 10 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 □ M 2 □ F Yrs. Ĩ915 West Virginia 88 Director 540--30--3555 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. Its Modical Examiner must be notified at 1X Yes 2 □ No Director Mountain Lake Park MD Garrett 10g. Citizen of What Country? 10e. Street and Number with 21550 USA 607 P St., Apt. Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, Its Musters Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ™ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nursing Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CONNELLY HOBAN Grace Jennie Bernard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1640 Oakwood DRive #116 W. Narberth, Pa. 19072 Anne M. Peniazek/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/29/04 \* 4 ☑ Donation 5 ☐ Other (Specify) Human Gift Registry Morrantown 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Fune al Service Licensee Jewn Oakland Md. 21550 32 S Second St. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Hepatobiliary obstruction due to malignancy 1 month /Medical **Examiner** atherosclerotic cardiovascular disease yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo this certificate : After this certification : After this certification : 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ၉ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral 6 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 01-29-200429c. License number title of certifier 29b. Signature and D30035 -(chu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) richter, M.D. 1533 Memorial Drive Oakland, MD 21550 Donald R. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 Registrar

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2001	04377
)*	Physici /Medi Examir	cal	1 Jack R. 01033 1 29 04	3. Time of Death 2322 M  Georges
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth Months Days Hours Min. (Month, Day, Year) Col	nplace (State or Foreign untry) ashington
aryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Medical Evartic errinist be rotified at once.	To Be Completed by Funeral Director	3   Widowed 4   Divorced   1795, Give   1973   1   Yes, 2½ No   Specify:   Specify:   Widowed   15. Decedent's Education   (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   16b. Kind of Business/life. DO NOT use retired)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (First, Middle, Maiden Sumame)   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi   2353 Wood Berry Dr., Bryans Rd.,   20a. Method of Disposition   12   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place)   18   Date   20c. Location - City or Town of the place   18   Date   20c. Location - City or Town of the place   20c. Location - City or Town of the place   20c. Location - City or Town of the place   20c. Location - City or Town of the place   20c. Location - City or Town of the place   20c. Location - City or Town of the place   20c. Location - City or Town of the place   20c. Location - City or Town of	nican Indian, o, etc.  nite  ndustry  /ernment  /p Code)  Md.  Town, State  am, Maryla
	Physician /Medical Examiner per prize per per per per per per per per per pe	licai Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death SCHOOL
O. Box 68	at the death certifics by the attending ph tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ery Day Year
	The law requires that ate has been signed page 2 should be de	Completed by	Recent continuous contributing to death but not resulting in the underlying cause given in Part I.  Recent coronary array and scale,  Diabetes, coronary array at scale,  Lyerand esterolemia.  236. Did tobacco use contribute to the contribute to t	posy findings available impletion of cause of
Division of Vital	Hospital or Attending Physician: The Anous after death. Funeral Director: Atter this certificate hitely filled in by the funeral director, page	Certification: To Be	1   Yes 2   No   Hospital: 1   Inpatient 2   FR/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Special	
DIV.	To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the f	Medical Certif		tated
٠	To the within 2 To the To the comple	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, 150005)  1/29/04  30. Name an address of person who completed cause of death (Item 23a) (Type, Print)	Day, Year)
20	)5) Sta Registr		31. Date filed (Month, Day, Year) 32. Resistrar's Signature	4

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Howard Frank Cobey, Sr. JAN 2004 3:38 AM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER
5. Social Security Number 6. Sex 7. Age CHARLES I, API, ATA
If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Year) Months 1 □ M 2 □ F Yrs. 216-16-0226 89 14,1914 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ital Hygiene. ed other then "natural", or items 23a or 28a-f ehov event, tra Medical Examiner mat be notified at 1 ☐ Yes 2 No Directo Maryland Charles Nanjemoy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20662 4075 Clarice Place U.S.A. Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "remy injury or other traumatic event, tra Mud once. Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Unknown Cobey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 2,20

Mamorial Gardens Wife Nanjemoy, Maryland 20662 Clarice Cobey Baltimore. 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □XBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 2004 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams Funeral Home, 4270 Hawthorne Rd., In M00668 Indian Head, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit The law requires that the death certificate be executed vace that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical detached for use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver, in Part II. 23e. Did tobacco use contribute to the cause of death? 8 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. as case referred to medical examiner? 1 Yes 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Medicel Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number D-0008370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL E. GRANGE AVE. P.O. BOX 1317 LAPLATA MD. 20646 PRITCHETT 118 31. Date filed (Month, Day, Year) State 3 0 Registrar

Jenn 04-0 RPD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Jenny Cra 04-00366 RPD	ıwı	Please . For	Type or Prin State of Ma	rylan	d / Depar	tment of I	lealth and I	Mental Hy	giene	_	01.370
		1 - State Registrar Unpend Item#2  1. Decedent's Name (First, Middle, Las		Per M	E, G8 <i>287,</i> 1	1/13/04 <del>0g</del>	Death	2. Date of De		to W O TY	3. Time of Death
Physicia /Medic		JENNY ELIZAE	BETH CRA	WFO	RD			Jändar	y Pay	, 2004	0942 A <sub>M</sub>
Examin		4a. Fecility Name (If not institution, give 267 Windjammer Ro			4	b. City, Town, o Berlin	or Location of Death	1	4c. (	County of Death Orcester	
Funeral Director		221-34-1926	8X 7. Age □ M <b>X</b> 1F	(In yrs. I 40		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10 / 15	v Year)	Cour	nlece (State or Foreign htry) DE
aryland ehow	7	Usuel Residence of Decedent  10a. State 10b. County			/, Town or Loca		•	- 1,		1	Od. Inside City Limits  1X Yes 2 □ No
the M	Director	MD Worces  10e. Street and Number	ter		Ocean	10f. Zip Code		1	10g. Citiz	en of What Cour	
with with		267 Windjamme	r RD			2181	1		-	JSA	,
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene do other then "neturel", or items 23s or 28s-f show event, the Medical Exertiner transities notified at	by Funerai	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:				Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No o Rican, etc.)	p- 1	4. Rece - Americ Black, White, Specify: Wh	etc.
be filed within 72 hours ital Hygiene. Id other then "neturel" event, the Medical Exi	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		<b>+</b> )	16a. Deceder (Give kir life. DC	nt's Usual Occu nd of work done NOT use retire	pation during most of world)	king	16b. Kin	d of Business/Ind	dustry
ygien ygien yer th	Con		2		Hoi	memake	T			wn Hon	ne
2 should be filed within and Mental Hygiene. Is marked other then aurnatic event, tra M	To Be	17. Father's Name (First, Middle, Last) Robert W. Crav	vford					Tathwel	1		
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic. Once.		19a. Informant's Name/Relationship (					Place No			Town, State, Zip	(Code)
1 and Health em 27 ther tr		Gail T. Nobles 20a. Method of Disposition	<u> </u>	20b. P	lace of Disposit emetery, crema					ation - City or To	own, State
Pages nent of nnt: If th		1 Burial 2 Cremation 3 . 4 Donation 5 Other (Specify	Removal from State				ce)  1/18 Crematory	/04		nkford,	
artme ortan Injur		21. Signature of Funeral Service		Ca			ess of Facility Th	o Burb			
Departiment on in in in in in in in in in in in in in		Jaws Wlen	loven no	2084	10	8 Willia	m St. Be	rlin, M	D 2	1811	nome
Physician		Immediate Cause (Final	plications that caused one cause on each line	е.			ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as e		ntoxicati uence of):	OIL					
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated exercises	Due to (or as a	consequ	uence of):						
icate be executed physician and sthe burial-transit	_	that initiated events resulting in death) Last	C Due to (or as a	consequ	uence of):						
ficate physis the	edica	`	d								
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ሺ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal	Ideath 3□E	ctopic pregnanc Other (specify) _	ey .		2	3d. Date of delive Month	ery Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in the und	erlying cause g	ven in Part I.			se contribute to the	ne cause of death?
The law re- ate has bee page 2 sho	Completed							24a. Was auto perfo		24b. Were auto prior to co death? 1 LL Yes	psy findings available impletion of cause of 2 No
ician: Th certificate rector, pag	ø	25. Was case referred to medical					26. Place of Dea			1 00 103	20110
nysician: nis certifica i director, i	To B	examiner? XXYes 2 □ No	Hospital: 1   Inpatier	nt 2 🗆	ER/Outpatient	3 DOA	her: 4 🗆 Nursing H	ome 5 🗆 Resi	idence 6	<b>∑</b> ther (Specif	) At Scene
	atlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation			28b. Time for Injury 9:42	aM 1 [	nyat ork? ]Yes 2 <b>X</b> No	28d. Describe subject		ed drugs	
al or Atte s after de ni Directo	Certific	3. Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Inju- building, etc residence	ry - At ho . (Specify	ome, farm, stree	t, factory, office		City or To	wn, State)	Road, Be	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funn	edicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best o niner: On the basis of and manner stat	examina	wledge, death o tion and/or inve	occurred at the t stigation, in my	ime, date and place opinion, death occu	and due to the	cause(s)	and manner as s	tated
To the To the Compl	Me	29b. Signature and title of certifier				29c. Licen	se number			signed (Month,	

State Registrar

DHMH 17 Rev 1/2001

LING 31. Date filed (Month, Day, Year)

hu.

LI

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

January 15, 2004

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,			For State Registrar	State of Marylar	•	artment of F rtificate of			leg. No.	004	04380
Н	Dhomini		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
П	Physicia /Medic	al		<u> </u>	Campbe		r Location of Death	Februa	4c. Count		10:55 P <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give s. Memorial Hospital	reet and ridinber)		Cumber				gany	
2000	Funeral Director		5. Social Security Number 6. Sex 1 - 1 - 1	7. Age (In yrs.	last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Jul 24,		9 Birthr	NOD
	land ow		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo					1	Od. Inside City Limits
	a-f eh	ctor	MD Allegan	у	Cum	berland					1 XYes 2 No
	ith with the 23a or 28 ust be no	rai Director	10e. Street and Number 102 First Street 1st			10f. Zip Code	21502			ISA	
036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or tems 23e or 28e-f ehow int, I'm Mydical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	I	Was Decedent of H If Yes, specify Cub  1 Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ nck, White, fy: whi	etc.
2-0	n 72 hours "natural", edical Exe	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worki	ng	16b. Kind of E	Business/In	dustry
7121	I within iene.	omp	Elementary/Secondary (0-12)	Cottege (1-4or 5+)		maker	5,		Own H	ome	
Maryland 21215-003	ed at a s	To Be C	17. Father's Name (First, Middle, Last)  John William He	trick			18. Mother's Name Bessie	(First, Middle, Mae (Bu			k
	ges 1 and 2 should t of Health and Men If Item 27 Ie marke or other traumatic		19a. Informant's Name/Relationship (Type Eleanor Guedel	sister	19b. Mailir 706	ng Address (Street 5 Catalpa	and Number or Rura Road	Frede	r, City or Town Prick	, State, Zip MI	) 21701
Baltimore,	Pages 1 au nent of Hea int; If Item iry or othe		20a. Method of Disposition  1 1 Sunal 2 Cremation 3 Re  4 Donation 5 Other (Specify)		cemetery, crer	sition (Name of matory or other pla Veterans (	ce)	2/9/2004	20c. Location Flints		own, Stafe MD
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	Austr	. 22		ili Funeral Hoginia Avenue		rland, MC	21502	
	Physician		23a. Pant. Inter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the dea e cause on each line.	sth. Do not ent	er the mode of dyin	ng, such as cardiac c	or respiratory ar	rest,		Approximate Intervat Between Onset and Death 2 HOLICS
	/Medical Examiner	J.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):	tis				i	2 Hours
	ficate be executed physicien and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
68760,	ficate be executed physicien and is the burial-transit	edicai E									
P.O. Box 6	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnanc Other (specify)	у			ate of delive	ery Day Year
ds, P.	uires that the de signed by the a Id be detached t	by	Part II. Other significent conditions con	tributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	1		ne cause of death?
Division of Vital Records,	The law requirence has been signated to be a special of the base o	Completed						24a. Was autop perfor	SV	Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mptetion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		OH	26. Place of Death				
5	Physic rthis or ral dir	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4   Nursing no	me 5 ☐ Resid 28d. Describe h			(y)
<u>o</u>	Attending Physician: or death. ector: After this certifics by the funeral director.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2□No				
Divis	or Attendation after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	reet, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occurr	and due to the cred at the time, c	cause(s) and m date and place	anner as s , and due to	tated. o the cause(s)
<b>)</b>	To th withir To th comp	Me	29b. Signature and title of certifier	8_		29c. Licen:	se number		<sup>29d.</sup> Date signi Februar		Day, Year) 2004
	N		30. Name and address of person who co			Print)			502		
	Sta	ite	Dr. Ahmad, Johnso	32. Registrar's Sign	nature						
à	Registi		EER 1 2 2004	Piedence L	× Age	the s					

DHMH 17 Rev 1/2001

ORIGINAL

	1	1 - For State Registrar Amend Item	State of M 23aperPHYG828	laryland / 2/12/04	Departm Б <i>Сеrtific</i>	ent of F ate_of	lealth and N Death		giene 2 Reg. No.	004	0438
		1. Decedent's Name (First, Middle	Last)					2. Date of Dea	ath Day	Year	3. Time of Death
Physicia /Medic:		medora C	ockey					01	03	04	11:45 AM
Examine		4a. Facility Name (If not institution,				-	Location of Death		4c. Cou	nty of Death	
			f maryla.				Himme If Under 24 Hrs.	mD	M	17	
uneral rector		214-15-9446	6. Sex 7. A( 1 ☐ M 2 🔀 F	ge (In yrs. last 23	Yrs. Mont	hs Days	Hours Min.	8. Date of Birt (Month, Da January	y, Year) 25,1980		olece (State or Forei otry) Cyland
<b>3</b> (1) (1)	-	Usual Residence of Decedent  10a, State 10b, County		10c, City, To	own or Location					1	0d. Inside City Limi
3	ō	Maryland Wicon	mico		lisbury						1 □ Yes 2 <b>∑</b> 1
Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avent. The Medical Entanti et mast ha notified at	rect	10e, Street and Number				Zip Code			10g. Citizen	of What Cour	ntry?
39 0	<u> </u>	418 Pinehurst A	Ave.			218	301		US	A	
E	Funeral Director	11. Marital Status	12. Was Decedent		13. Was De	ecedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	14. F	Race - Americ	
Xarrina	by Fu	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		No		s 2 X No	Specify:	7 FIGATI, 6(6.)		Black, White, cify: W	hite
Sel	ed	15. Decedent	s Education		6a. Decedent's l	Jsual Occup	ation		16b. Kind o	f Business/In	dustry
Medi	Completed	(Specify only highes. Elementary/Secondary (0-12)	t grade completed) College (1-4or	5+)	(Give kind of life. DO NO	work done	during most of world)	king			
The The	EO	12	4	- '	Student				Educa	ation	
vent	Bec	17. Father's Name (First, Middle, L					18. Mother's Nam	e (First, Middle,	Maiden Sun	name)	
tlc	2	James A. Cockey	Y				Cather	ine Luse	}		
raumatic avent. Its M		19a. Informant's Name/Relationsh		- 1		•	and Number or Ru				
i i		James A. Cockey,	/father	OOL DI			st Ave.,	-			
or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State	ceme	of Disposition ( etery, crematory	or other plac	(e)	Date /O.4		on - City or To	
jury		'4 □Donation 5 □Other (Sp	•	Sall	sbury C					sbury,	
Important: If any injury or once.		21. Signature of Funeral Service L	Neumer	(FSP	<sup>2</sup> HÖİ 501	16Way° Snow	fuheral Hill Rd.	Home Pro , Salisb	fessioury, N	onal As MD 2180	ssociatio 04
sician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause only one cause on each	ed the death. Eline.	onot enter the	0	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
edical		resulting in death)	Due to (or as	s a consequen	_	1				<	5 /
niner	.	Sequentially list conditions,	U.	ECROSIS						- 1	days
sit	Examiner	d any, leading to in recitate cause. Enter Underlying Cause (Disease or injury	Due to for as	s a consequen	ce of						
the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	s a consequen	ce of):						
buria	a E				,-						
s the	edicai		d								
nse a	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of delive	ery
d be detached for use as	cia	in the past 12 months? 1 ☐ Yes 2 X No	4☐Pregnant a	2 Fetal death		ic pregnancy (specify)				Month	Day Year
tache	Physician/Me	9 □ Unknown	9 Unknown								
ep ec	by P	Part II. Other significant conditio	ns contributing to death	but not resultin	g in the underlyii	ng cause giv	en in Part I.	23e. Did to	bacco use c		ne cause of death?
should								101	es 2 No	3 ☐ Prob	ably 4 Unknow
2 sh	Completed							24a. Was		b. Were auto	psy findings availab mpletion of cause of
page 2	Com							perfo	med? 22 No	death?	2 <b>X</b> No
rector, pag	Be (	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)		
al dire	2	1 ☐ Yes 2 No	Hospital: 1 Ninpat			DOA Oth	4   Nursing H	ome 5 Resid			y)
funera	ou:	27. Manner of Death 1 Natural 5 ☐ Pending		ay Year) 28	b. Time of Injury	28c. Injun Wor		28d. Describe h	low injury occ	curred	
the f	Certification:	2 Accident investig 3 Suicide 6 Could n	ot bo		M		Yes 2 □No	204	Sanata and St.		/ Double Allembar
in by	it i	4 Homicide determi	ned 286. Place of in building, e	etc. (Specify)	, farm, street, fac	ctory, office		City or Tou	m, State)	moer or Hura	I Route Number,
completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	g Physician: To the bes	t of my knowled	dge, death occur	red at the tin	ne, date and place,	and due to the	ause(s) and	manner as si	ated.
letely	Medical	(Check only 2 Medical i	xaminer: On the basis and manner s	of examination	and/or investiga	tion, in my o	pinion, death occur	red at the time,	date and place	e, and due to	the cause(s)
фшо	ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
		X da	llasta.	MM		P	16546	2	DILAZ	12 000	1
		30. Name and address of person	who completed cause of	death (Item 23	a) (Type, Print)	- 1	~ ~ ~ ~		-100	120-	1
		1 Catherine	Gallagher	mp	295	Gre	ine sh	cet Bo	utm	ne w	1021201
Stat		31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	4	lan-	41			7	
egistra	ar :	JAN 0 8	3 2004	neva		your					

			1 - State Registrar Amend Item#28	State of M	aryland / Depa	artment of	Health an	d Mental Hy	_	04382
			Registrar Priento I Lettir 20     Decedent's Name (First, Middle, Las		-/12/04 EN 00			2. Date of De		3. Time of Death
	Physici		Eileen Karen Campl					January	y 9, 2004	1:45P M
	/Medic Examin	aı -	4a. Fecility Name (If not institution, give			4b. City, Town,	or Location of D		4c. County of De	
		ÇI	Shady Grove Adven	tist Hosp	ital	Rockv	ille		Montgome	ry
	Funeral		Social Security Number 6. S		ge (In yrs. last birthdey)	If Under 1 Yea Months Days		Hrs. 8. Date of Birt	th 9. B	irthplece (Stete or Foreign Country)
	Director		210-00-3/93	□M 2180F	47 Yrs.	Working Day.	, louis	Jan. 18	3, 1956 Man	cyland
	pud *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryli sho	5	Maryland Montgome	rv	Rockville					1 ☑ Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?
	3a or	ā	2014 Baltimore Ro	ad, #H22		208	51		United Sta	tes
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of	Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - An Black, Wh	nerican Indian,
9	after or Ite	Fu	1 Never Married 2 Married	1 ☐ Yes 21 ☐	No	1 ☐ Yes 21X No		deno rucan, ecc.,	Specify:	me, etc.
8	hours after death with the Maryland turel', or Items 23a or 28a-f show at Examinet - unt be notified at	d by	3 ☐ Widowed 4 反 Divorced	Year or Dates:					W	hite
<u> </u>	'nat	ete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of red)	working	16b. Kind of Busines	s/Industry
12	be filed within 72 hours after death with the Marylan ital Hygiene.  Id other than "natural", or Items 23a or 28a-f show of other than "natural", or Items 23a or 28a-f show event, the Macified at	Completed	Elementary/Secondary (0-12)	College (1-4or 2	5+)	ncial An			Federal Go	vernment
<b>D</b>	filed Hygi other		17. Father's Name (First, Middle, Last)					Name (First, Middle,		
<u>a</u>	Mental Mental arked c	To Be	Donald F. Brown				Mary N	Margaret K	eyser	
Maryland 21215-0036	St. DE E		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Stree	et and Number o	or Rural Route Numbe	er, City or Town, State	Zip Code)
Σ	1 and 2 Health a tem 27 is		Stephanie Marie H	ungerford			th Stree			
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo	osition (Name of matory or other pi OT Heave	Jar	Date n. 13,	20c. Location - City of	or Town, State
Ë	Page and Page		* 4 □Donation 5 □ Other (Specify	)	Cemet	tery		2004	Silver Spr	ing, MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce.		21. Signature of Funeral Service Los	1	Ro	2. Name and Add ockville	ress of Facility I	Robert A. 300 West M	Pumphrey F	uneral Home/ Avenue.
	00 = 0			M00	0.89	Ro	ckville.	Maryland	ontgomery 20850-280	5 Approximate
Ę.			23a. Part1. Enterthe disease, or com shock, or heart failure. List only	one cause on each I	ine.	(er the mode of d)	ying, such as cal	rulac or respiratory at	1651,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		rovascular	Acciden	t			4 days
	Examiner			Cereb	s a consequence of): ral Herniat	tion				1 day
4	01.3	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	a consequence of):	21011				12 443
	cuted nd ransit	Examiner	that initiated events	V	nal Carotio	l Artery	Disecti	ion		4 days
760,	te be executed ysician and e burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):					
876		dicai		d						
x 68	leath certificate b attending physic I for use as the b	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy	(1)			O2d Data of d	ali an
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnan	су		23d. Date of d Month	Day Year
o.	to the de by the dached	Physician/Medi	1 ☐ Yes 2 XNo 9 ☐ Unknown	9□ Unknown						
<u>a</u>	de de	y P	Part II. Other significent conditions of	ontributing to death t	out of ulting wine u	indelitying cause g	given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	quires n sign ald be	d by		1	may O.	(2)		101	res 2 No 3 1	Probably 4 DUnknown
00	sw requir s been si 2 should l	ojete		Vices of	Misser!			24a. Was		autopsy findings available
Re	The lay	Completed		Carlo Carlo				— autop perfo 1 ☐ Yes	rmed? death?	completion of cause of
Vital Records,		Bec	25. Was case referred to medical				26. Place of	Death (Check only o		
of V	di si	70	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1X Inpati	ent 2 ER/Outpatie	IL SELDON		ng Home 5□ Resid	dence 6 Other (Sp	ecify)
		ë.	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju	ay Year) Injury	W		28d. Describe I	now injury occurred	
sio	at ac	cati	2 ☑ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	Dec. 0, .		-23	∐Yes 2X∏No		fell on	
Division	after de Direct	Certification:	4 Homicide determined	building, e	jury - At home, farm, st tc. <i>(Specify)</i> idewalk of	home	8	2014. B	Street and Number or I vn, State) altimore R ille, MD 2	gad.
	Hospitel		29a. Certifier 1 Certifying Ph		of my knowledge, deat		time, date and p			
	To the Hospitel or Attu within 24 hours after de To the Funerel Directo completely filled in by th	edical			of examination and/or in					
	To the within 2 To the comple	Me	29b. Signature and title of certifier				nse number		29d. Date signed (Moi	
, i	0		· All	MMV		D403	<b>33</b>		January 11	, 2004
,			30. Name and address of per in who	completed cause of						
			James Yan, M.D. 1					Le, MD 208	52	1
B	e Sta Regist		31. Date filed (Month, Day, Year)  JAN 16 2		rar's Signature	Sport	ls!			

Amended Item 1 per Physician 01/23/2004 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 3.30 PM **MYRTA** MAE DEHOFF Janua ! 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Brroll Hospital enter Carroll If Under 1 Year | II Under 24 Hrs. 5 Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🖾 F 219-22-1567 Director 99 Jan 24 1904 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Midical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Park View Terrace Items 23a 21157 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Black. White, etc. 1 Never Married 2 Marned Maryland 21215-0036 ŏ 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene important: If Item 27 is marked other than any injury or other traumatic event, Ins. Mode. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Colonel Wallace Osbun ပ Anna Mehaffey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clyde DeHoff/son 115 Tiffany Lane Gettysburg, PA 17325 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Park 1/26/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD permit. 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsis **Physician** pays resulting in death) /Medical Due to (or as a consequence of) Examiner per torated Bays Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. Stitl 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate 1 Yes 2 No Vital director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA of this tuneral ( 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL D0059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Abel, Mip 295 Toner Westminster, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Den

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 04385 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month ETHEL. DAVIS 11:13 A<sup>M</sup> 01 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yr. 85 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 12/13/1918 5. Social Security Number 579–50–9097 yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Wash. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exentiner must be notified at 1 Yes 2 □ No Director Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 200 Rhode Island Ave. NE 20002 238 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: or items 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3X Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government mit. Pages 1 and 2 should be filed within nartment of Health and Mental Hygiene. ortant: If item 27 is marked other than injury or other treumatic event, it a Maring or other treumatic event, it a Maring or other treumatic event, it a Maring or other treumatic event, it a Maring or other treumatic event, it a Maring or other treumatic event, it a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a Maring or other treumatic event, it is a market event eve Elementary/Secondary (0-12) 12th College (1-4or 5+) Postal Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lewis Overton Lena Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Washington, Niece 1248 Farragut Pl. NE. Washington, DC. 20017 Baltimore, 20b. Place of Disposition (Name of Glerwood Cemetery). 20a. Method of Disposition 20c. Location - City or Town, State 01/27/04 1 Burial 2 Cremation 3 Removal from State Washington, DC. permit. Page Department o Important: If sny injury or \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bianchi F.S. 814 Upshur St. NW, Washington, DC. 21. Signature of Funeral Service Licensee 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Disseminated DAYS /Medical Due to (or as a consequence of) SEPSIS Examiner WEGGS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit 1 MONTH DECUFITUS Due to (or as a consequence of): Box 68760 6 months [MMOBIL Physician/Medical as for use a IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ THENOSCIENCTIC CARDOUNDULLAR cate has been signated by page 2 should b Ńο 3 Probably 4 Unknown 1 Tas Completed EMBOLISM 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Yo 24a. Was an certificate has autopsy performed? 1 Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ER/Outpatient 3 DOA this funeral 27. Monner of Death 1 Deatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: il or Attending F gatter death. I Director: After After 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Z Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Han New pulie Are lakma Kark 2091 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 Day **Physician** 2004 М 2.4 7:10 DOROTHY DAGGETT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 18 1935 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours Min. GEORGIA 1 ☐ M 2 🔀 F 68 Yrs. 079-30-0937 Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State or than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at XXYes 2 No PRINCE GEORGE'S MD LANDOVER Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with U.S.A. 20785 6915 KENT TOWN DRIVE death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind al work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier important: if item 27 ie marked other the profiler of the traumatic event, Lagonse. SENIOR COORDINATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAGGETT/DAUGHTER 15725 MILLBROOK LANE LAUREL, MARYLAND JOYCE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 1-31-2004 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of) Examiner HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit DIABETES and Due to (or as a consequence of) Box 68760. physicien HYPERTENSION for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 0.0 detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à page 2 should be CEREBRAL VASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? CONARY ARTERY DISEASE 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No After this certification or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending М 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1/26/2004 D34472 30. Name and addre LYNNE D ddress of person who completed cause of death D. DIGGS M.D. 10400 CONNECTICUT AVENUE KENSINGTON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 04387 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 28, 2004 Year **Physician** Santo DiStefano Α. 11:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Months Days Hours Min. (Month, Day, Year)

Mar. 27, 1910 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 220-14-3390 93 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Itams 23a or 28e-f shov the Medical Examiner must be notified at Md. Montgomery Rockville 1 XYes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. fited within 72 hours after Allied Polices! 1 | Yes 2 | No If Yes, Give Year or DatesUnknown 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Barber Hair Styling 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filt timent of Health and Mental Hy tant: If Item 27 is marked oth jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) Be Phillip DiStefano Jennie Cataneri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs.Janice Kulis-Daughter 6410-New London Rd., New Market, Md. 21774 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of I Important: If Ite any injury or of 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2/2/2004 Baltimore, Md. permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hysong Co., Inc. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. M My 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) Unknown /Medical Due to (or as & consequence of): Examiner Preumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last unkhown Que to (or as a consequence of Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2☐No 0 detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by critical aorthe stenosis 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an page 2 s autopsy 1 ☐ Yes 2 XNo Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Usten Vailen House mo January 28, 2004 D0059871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Howe MD 9901 Medical Center Drive Rockerile, margiand 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Items#24a.25.26.27.29cperPHY Certificate of DeathG8282/12/04EW Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 0140 AM David Lambert Divelbiss January 21 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. Washington 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 XM 2 ☐ F 93 1911 Mercersburg PA Director 173-03-1246 Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ent: if Itam 27 ie marked other than "natural", or itams 23e or 28s-1 ehov ury or other traumatic event, the Medical Examinant par notified at 1 ☐ Yes 2√2 No Director Waynesboro Franklin 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10650 Buchanan Trail E 17268 <u>USA</u> Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Yes Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) Machine company Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David W. Divelbiss Jennie B. Pensinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen V. Divelbiss, spouse 10650 Buchanan Trail E Waynesboro, PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2004 1XXBurial 2 Cremation 3 Removal from State Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) January 23. Burns Hill Cemetery 22. Name and Address of Facility 50 S Broad ST Waynesboro, PA 21. Signature of Funeral Service Licenses 100menson Grove-Bowersox Funeral Home 23a. Part . Pytter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death accident-Immediate Cause (Finat erebro Vasculen **Physician** disease or condition resulting in death) /Medical Examiner Den Knilm Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical tF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔯 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Attending 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 6 Could not be 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide hours after To the Hospital or within 24 hours a To the Funerel I 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 22136 an Ros Roben word Center Horfes ( Way las) who completed cause death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar

Swell 227

31. Date filed (Month, Day, Ye

wester

11110

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February William Edward Day 2004 1900 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Carroll County Westminster Nursing & Rehabilitation Center Westminster 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 58 Yrs. | Months | Days | Hours | Min. | Feb. 25, 1945 Birthplace (State or Foreign Country) 5. Social Security Number 1 XM 2 □ F 212-42-7939 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Carroll County 1⊠Yes 2□No Maryland Taneytown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 28 East Baltimore Street 21787 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - Americen Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) forestry worker tree service 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edward Day Fay Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Bell / sister 7696 Altoona Beach Road Glen Burnie, MD 21060 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 9 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State Feb. Trinity Lutheran Cemetery Taneytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Euperal Service Licensee 136 East Baltimore Street Taneytown, MD 21787 unn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? available prior to completion of cause of death? 1 Yes 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined

Box 68760, P.O. of Vital Records,

ettending physician end for use as the burlel-transit The law requires that the death certificete be exer been this certificete hes To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director; to Division

**Physician** 

Examiner

**Funeral** 

Director

r than "neturel", or iteme 23a or 28e-f shor the Medical Examiner must be notified at

Hygiene.

Peges 1 end 2 should be filed vent of Health end Mental Hygient: If Item 27 is merked other t

Department of Health er Important: If Item 27 Is eny Injury or other trau

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

/Medical

Director

<u>۾</u>

Completed

Be

၉

Examine

Physician/Medicai

₹

Be

၉

Certification:

Medical

3 Suicide

4 Homicide

page 2 should Completed

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Poole Road, Westminster deletin 688 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

2



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amended Item 23a Part I b,c,d per Physician & Item 9 per F.D. 01/23/2004 Carroll Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene o wi1 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jack **Physician** 10 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Co Cumbis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. NEW place State or Foreign 6 Sex 7 Ann (In vrs last/birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 3€ F 88 May 27, 1915 Director 117-20-8668 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show ns 23a or 28a-f shor Westminster 1 ☐ Yes 2 No Carroll Completed by Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NICE 21158 SA 210 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? The Mudical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 ö Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) and Mental Hygiene. 7 is marked other treumatic event, if 17 Father's Name (First, Middle, Last) Be ٥ 10b Mailing Addrass Street and Nymbe other 20a. Method of Disposition Department of Important: If It any injury or o 1 Burial 2 Cremation 3 F 3 Removal from State 7110 2-10 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) aula **Physician** more /Medical Due to (or as a consequence of): Examiner nemou 1 willy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE HEART FAILURE 5 Weeks 7 To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician 2-3 Months Physician/Medical CANCER, RIGHT COLON the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 1 Yes 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 2 Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ARISCH 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of d 1)00 16830 MJL KIRAN PARIKH, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Hall 480 032 32. Registrar's Signature State Registrar **JAN 23** 

DHMH 17 Rev 1/2001

OPIGINIAL

			For State Registrar	State of	Maryland		artment <i>tificate</i>			nd M		iene	004	04391
			Decedent's Name (First, Middle, La	ist)							2. Date of Deat	h		3. Time of Death
	Physicia		KATHRYN	5	5.	EV	ERETT				Month January	Day 19, 2	Year 2004	2:45 A M
	/Medic Examin		4a. Facility Name (If not institution, gir	re street and nun	n <i>ber)</i>		4b. City, T	own, or l	Location of	Death		4c. Cou	nty of Death	
	LXaiiiii	Ç.	Frederick Memor	ial Hosp	oital		1	Frede	erick				Freder	cick
	Funeral			,	7. Age (In yrs. la	st birthdey)		Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
	Director		215-20-3015	1□M 2 <b>⊠</b> F	77	Yrs.	Months				July 20	, 1926	Ohio	
	D .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation						1	0d. Inside City Limits
	anyla shov	_		٦		t Air							-	1 ☐ Yes 2 ☐ No
	Ba-f	Directo	Maryland Howar	u	Houn	L AII.	10f. Zip (	Codo			1	On Citizen	of What Cour	ito?
	vith t	급	10e. Street and Number 17330 Frederic	k Road				2177:						tates
1	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or Itema 23s or 28s-f show event, the Medical Examinar must be notified at	Funerai			dent Ever in U.S	13 1				in? (Spe	city Yes or No-		Race - Americ	
	er de Item	, u	11. Marital Status  1 □ Never Married 2 ☑ Married	Armed Fo	rces?	. 13.	f Yes, speci	fy Cubar	, Mexican,	Puerto I	cify Yes or No- Rican, etc.)	E	Black, White,	etc.
50	hours after tural', or ite	byF	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	'e		1 ☐ Yes 2	No No	Specify:			Spe	city: Whit	te
2-003p	tura stura	b B	15. Decedent's E	ducation		16a. Dece	dent's Usua	Occupa	tion				f Business/Inc	
C   2	in 72 n "naf	Completed	(Specify only highest gi	ade completed) College (1	-4055+)	(Give life.	kind of word DO NOT us	k done di e retired)	uring most	of work!	ng			
7	filed within Hygiene. other than " ant, the Mes	Eo	12	College ( )	401 347	Hor	memake	er				Own	Home	
ğ	filed Hygic other	Be C	17. Father's Name (First, Middle, Las	t)					18. Mother	r's Name	(First, Middle, M	Maiden Sun	name)	
<u>a</u>		To B	Elmer Ma	rtin	Scott				Ru	rth	Elai	1e	Teagle	2
			19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Number	City or To	wn, State, Zip	Code)
	and 2 ealth a n 27 ls		James L. Ev	erett /	Spouse	173	30 F1	rede	rick	Rd.	/ Mount	Airy,	, MD	21771
altimore,	item item othe		20a. Method of Disposition		Ce	ace of Dispo	sition (Nam matory or ot	e of her place	)	D	ate	20c. Locatio	on - City or To	own, State
Ē	permit. Pages 'Department of H Important: If ite any injury or of Once.		1 ☐ Burial 2 【 Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		Fre	deric	k Cre	nato	ry Ja	an.2	3,2004	Frede	erick,	Maryland
a	mit. Dartm Dorts / inju	1	21. Signature of Funeral Service Lice	nsee	_	22	2. Name and	d Addres	s of Facility	Sta	uffer F	ınera	1 Homes	s, P.A.
ğ	De la la la la la la la la la la la la la		Baymone	Cell	rem		8 E. I	Ridge	evill	e B1	vd./ Moi	int A	iry, M	21771
			23a. Part1. Errer the disease, or con shock of heart failure. List only	nplications that o	aused the death	. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	^			40.							Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a consequ	ence of):	<u> </u>							,,,,,
	Examiner		O at the first and distance	, E	maler	emer								Laur
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to	(or as a consequ	ence of):			-					0
	cuted	Examin	that initiated events	c										
o,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	M.	resulting in death) Last	Due to	(or as a consequ	ence of):								
8760	ate be nysici he bu	dicai	•	d										
3	ng pt	Zed	IF FEMALE:											
Вох	leath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregnar pirth 2 Tetal	death 3	⊒Ectopic pre					23d.	Date of delive Month	ory Day Year
Ç.	e dea he at hed fo	Sici	1 Yes 2 No	4∐Pregr 9□Unkn	nant at time of de own	ath 5	Other (spe	ecify)						
0.	that the de led by the a detached f	P.	Part II. Dther significant conditions	contributing to d	anth hut not room	Iting in the u	andorhina or	auco dive	on in Part I		23e Did to	nacco use c	contribute to the	ne cause of death?
ś	res tha	ρ	Part II. Diner significant conditions	contributing to a	eath but not resu	iting in the d	indeniying o	ause give	WI IN 1 21(1,			s 2 12 N		oably 4 Unknown
ord	w require been sig should b	ted	Lang Ca	nuv	£						-			-
Ö	has b	pje	Dialily	melle	tur						24a. Was a autops perform	y	prior to co death?	psy findings available mpletion of cause of
<u> </u>		Completed										ZNo	1 ☐ Yes	2 No
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 4				Otho		of Death	(Check only on	e)		
$\leq$		မ	1 ☐ Yes 2 ☐ No			ER/Outpatie			4 140		me 5 Reside			y)
Ē	Jing P	0	27. Manner of Death 1 △Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time o Injury	M	8c. Injury Work	ຕີ່ ∕es 2⊡1		200. Describe no	W sijuly oc	Carred	
Division of Vital Record	Attending Physician: or death. ector: After this certifics by the funeral director.	cat	2 Accident investigate 3 Suicide 6 Could not		of Injuny - At ho	mo farm st			. 63 2		28f Location (St	reet and N	umber or Run	al Route Number,
<u>≥</u>	of or Attendated after death Director:	Certification;	4 Homicide determine	d build	of Injury - At hor ing, etc. (Specify	)	reet, lactory	, onios			City or Town			,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying I	hysician: To the	e best of my know	wiedae, deat	h occurred	at the tim	e, date an	d place.	and due to the c	ause(s) and	manner as s	tated.
	Hos 24 ho Fun stely	edical	(Check only 2 Medical Ex-	sminer: On the b	asis of examinat	ion and/or in	vestigation,	in my op	inion, deat	th occurr	ed at the time, d	ate and pla	ce, and due to	the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Med	29b. Signature and title of certifier				290	. License	number		2	9d. Date si	gned (Month,	Day, Year)
•	F ≱ F 8		VAIL	2/11/2 11/	1 1/1			$\cap$	72	ici		A	. 27	1 006
	10		30. Name and and ass of person wh	o completed cau	se of death (Item	23a) (Type	Print)	1)	12	( )	14	me	4 1-	1007
	1 -		1-10-11 14	10 (11)	(A- 1111	(4	75	ta	ne	a.	u 1	red	ench	2014 J(X)
	St	ate	31. Date filed (Month, Day, Year)	32. F	legistrar's Signat	ture	la. H.	,	· (					
	Regist		JAN 26	2004	Solder .	Air for	13 SA							

State of Maryland / Department of Health and Mental Hygiene

			State of Maryla		Certificate			Reg. No. 2 () ()	4 04392
	Physician	1. Decedent's Name (First, Middle, Last)	TANTE A	CNES	EIGENBROI	)F	2. Date of De Month January	Day Ye	3. Time of Death 4 10:29 AM
N.	/Medical Examiner	4a Fecility Name (If not institution, give s		GNES	EIGENDRO	4b. City, Town, or			
1	LAUTITIO	Beverly Healthcar			I Killadari t V	Frederic		Freder	
	Funeral Director	5. Social Security Number 6. Sex 249-07-4943	7. Age (In y	83 Yr	Months   D	ays Hours Min		<sup>th</sup> Year) 9.4, 1920	Birthplace (State or Foreign Country) South Carolina
	inylend ihow	10a. State 10b. County		City, Town					10d. Inside City Limits 14 Yes 2 □ No
	vith the Mer or 28a-1s be notified Director	Maryland Frederic	k F	reder	ick 10f. Zip Co	10		10g. Citizen of Wha	
	uth with the Meryler 23a or 28e-f show ust be notified at rai Director				2170			U.S.A	
	r thems 23	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S.	13. Was Decedent If Yes, specify	of Hispa <i>n</i> ic O <i>ri</i> gin? (S Cuban, Mexica <i>n</i> , Puer	Specify Yes or No rto Rican, etc.)	14. Race - A Black, V	American India <i>n</i> , White, etc.
020	o N	3X Widowed 4 ☐ Divorced	1 ☐ Yes 2♠ No If Yes, Give Year or Detes:		1 ☐ Yes 2 ☐	No Specify:		Specify:	White
Baltimore, Maryland 21215-0020	ed within 72 hours efter ygiene. Ner than "natural, or int, the Medical Examint, the Medical Examint).	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. D	Decedent's Usual O	ccupation one during most of wo stired)	orking	16b. Kind of Busin	ess/Industry
2121	iene. iene. ithen	Elementary/Secondary (0-12)	College (1-4or 5+)		ress Open			Cambridge	Rubber Co.
nd	<b>= 1 4 5 6</b> 60	17. Father's Neme (First, Middle, Last)		-			me <i>(First, Middl</i> e, n Unknow	, Maiden Sumame)	
ryla	hould be d Mentel marked o matic ev	Herbert Lee Davis	na Print)	19h I	Mailing Address /S	reet and Number or R			te. Zip Code)
Ma	nd 2 si alth en 27 is r ir traus	Cameron L. Eigenbr				Drive, T			
ore,	ges 1 e it of Heis	20a. Method of Disposition 1 ◯XBurial 2 □ Cremation 3 □R			Disposition (Name of crematory or other		Date	20c. Location - City	
Itim	permit. Peges Depertment of I important: if Ite any injury or o DICE.	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	R.				ge, Maryland		
Ba	perm Depe impo any i	X446	To Cours			MAIN ST.,			
		23a. Part1. Inter the disease, complishock, or heart failure. List only on	cation to cause the	ath. Do no	t enter the mode of	dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical	Immediate Cause (Final	\L	4-	1				Onset and Death
	Examiner	disease or condition resulting in death) a	Due to	(or as a co	insequence of):	Can	ree_		0735
-	sit ed		)						
Ć,	ificete be executed g physicien end es the buriel-frensit edlcal Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to	(or es a co	nsequence of):				, 1 1
68760,	ficete be physicie ss the bur edical	Cause (Disease or injury that initieted events resulting in death) Last	Due to	(or as a co	nsequence of):				137
	- OI 0 -								
Box	et the death cert d by the ettending eteched for use Physician/M	Part II. Other eignificant conditions con	tributing to death but not r	esulting in t	he underlying caus	e given in Part I.	23b. Did	tobacco use contri	bute to the cause of death?
P.0	es that the death certificioned by the ettending p be deteched for use es by Physician/Me						10	Yes 2 No 3	□ Probably 4 □ Unknown
of Vital Records,	The law requires that the death cert elet hes been signed by the ettendin page 2 should be deteched for use Completed by Physician/N	10					24a. Was	an autopsy 2	4b. Were autopsy findings available prior to completion of cause
Sec	The law require sete hes been si page 2 should		·				101	Yes 22No	of death?
tal						26. Place of De	eath (Check only		TO THE ZONO
Ž	hysicia this cer el direc	1 ☐ Yes 2 No			patient 3 DOA			dence 6 □Other (	(Specify)
ouo	T 0	27. Manner of Deeth  1 ✓ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tir Inj	me of 28c. ury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe	how injury occurred	
Division		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	home, fam cify)	n, street, factory, of	fice	28f. Location ( City or To	Street and Number own, State)	or Rural Route Number,
_	Hospi 4 hou Funer tely fill	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	siclan: To the best of my k nar: On the basis of exami and manner stated.	nowledge, onation end/	death occurred et to for investigation, in	ne time, date and plac my opinion, death occ	e, and due to the curred et the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	29b. Signature and title of certifier	and mainer stated.			cense number	· · · · · · · · · · · · · · · · · · ·	29d. Date signed (A	Month, Day, Yeer)
	> - 0	<b>)</b> ())				721944		1/23/	104
-	2	30. Name and address of person who co	mpleted cause of death (I	and a	ype, Print)	6 204	FREDER	KK MD	20702
r	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig		. South	,		( )	

			1 - For State Registrar	State of	f Marylan				ealth a Death	ınd M		Reg. No.	200	04 0439	3
<b>&gt;</b>	Physici /Medic Examin	cal	Decedent's Name (First, Middle, Las     Ruth Virginia E     4a. Fecility Name (If not institution, give	pps	nber)		4b. City	, Town, or	Location o	f Death	2. Date of De.	Day 25		ear 3. Time of Death	A
		<	Doctors Communit  5. Social Security Number 6. Se		ital 7. Age (In yrs.	last hirthday)		anhar	m If Under a	24 Hrs.	8. Date of Birt			George's	20
	Funeral Director			M 200	83	Yrs.	Months		Hours	Min.	(Month, Da 12/31/	v. Year)		D. Birthplece (State or Foreig Country) Nash.,D.C.	
	fand •••		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limit	s
	e Mary	ctor	Md. P.G.			Chape	el Oa	ks						1 <b>X</b> Yes 2 □ N	o —–
	death with the Maryland ms 23a or 28a-f show	Dire	10e. Street and Number 1327 Farmingdale	Ave.			10f. Z	p Code	20743			10g. Citi:	zen <i>o</i> f Wh: U.S.	at Country?	
		Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	J.S. 13.	Was Dece			gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	.	14. Race -	American Indian, White, etc.	
5-0036	hours after tural', or ite	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 🗀 Yes If Yes, Giv Year or D	/8		1 🗆 Yes	2 <b>√</b> No	Specify:				Specify:	Black	
-c-:	within 72 ho ene. than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1	1-4or 5+)	16a. Dece (Give life.	dent's Usi kind of w DO NOT	iai Occupa ork done d ise retired	ation during most f)	of work	in <i>g</i>		nd of Busin R.A.	ness/Industry	
7 7	filed with Hygiene other the	Com	12th	Obliege (1		Ca	feter	ia W	orker		e (First, Middle,			Industry	
and		To Be	17. Father's Name (First, Middle, Last)  Thomas Jacksor	1							ce Park		Surname)		
Maryland	2 should be and Mental is marked is marked	F	19a. Informant's Name/Relationship (7			19b. Maili	ng Addres	s (Street a	and Numbe	r or Rura	al Route Numbe	er, City or	r Town, Sta	ate, Zip Code)	
	s 1 and f Health item 27 other tr		Henry Edward Lee/ 20a. Method of Disposition	5011	20b. I	1327 Place of Dispo	Farn osition (Na	ingda	ale A	ve.,	Chapel Date	Oaks 20c. Lo	Md. cation - Ci	ty or Town, State	
Ö E	8°= 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			cemetery, crei incoln				/31/	04	Sui	tland	d, Md.	
Baltimore,	ermit. Pa Separtmen mportant: ny injury mcs.		21. Signature of Funeral Service Licen	. /)	all	_	ис	Mach	s of Facilit	n 8	Sons Co	.,Tn	c.		
	Physician		23a. Part1. Prier the dis ase, or compshock, or heart failure. List only	olications that cone cause	aused the dea	th. Do not en	925 F ter the mo	de of dyin	g, such as	Ave.	of respiratory a	Was	h.,Ð.	.C. 20010 Approximate Interval Between Onset and Death	
	/Medical Examiner	ı	disease or condition resulting in death)	a. Due to	(or as consec	quence of):	128	0	-1		dina	20	2	Moore	
	be executed sician and burial-transit	Examiner	Sequentiary list our ditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec			V						1	
8760	# × 6	cal	· ·	. d											_
.O. Box 6	at the death certificat by the attending ph) tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 Live b	tcome of pregn birth 2 Teta nant at time of c own	al death 3[	⊒Ectopic ⊒ Other (s	pregnancy pecify)				2	23d. Date of Month		
٥.	uires that I signed by Id be deta		Part II. Other significant conditions of	ontributing to d	eath but not re	sulting in the u	underlying	cause give	en in Part I					ute to the cause of death?	m
Il Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed											pride	ere autopsy findings availab or to completion of cause of ath? Yes 2 \(\sum \text{No}\)	le
Vita	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:	Factions 25	] ER/Outpatie	nt 3[] [	Oth	or		h <i>(Check only c</i> me 5 ☐ Resi		S COther	(Specify)	
n of	Attending Physician: The r death. ector: After this certificate his by the funeral director, page	H	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28 a. Date (Mon	-	28b. Time of Injury		28c. Injun Worl			28d. Describe				
Division of Vital	l or Attendatter death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		of Injury - At hing, etc. (Speci	nome, farm, st			163 2		28f. Location ( City or To	Street and vn, State	d Number )	or Rural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier Certifying Ph (Check only one)	niner: On the b	e best of my kn pasis of examin iner stated.	owledge, deal atipn and/or in	th occurre	d at the time.	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) date and	and mann place, and	ner as stated. d due to the cause(s)	
	Vithin to the Comple	Med	29b. Signature and title of certifier	A	J. J. J.	/	2	9c. Licens	e number			29d. Dat	e signed (	(Month, Day, Year)	
•			m	dus	1			02	89	20	1	1 -	- 26	-2004	
	(5)		30 Name and address of person who	completed cau	se of death (Ite	3/9/	Print)	Ha	nave	1	arkwa	M	G	reenbelt	
	St Regist	tate	31. Date filed (Month, Day, Year) JAN 2 9 2004	1	Registrar's Sign	nature	20	4 200			ur pr	0	111	1. 20/10	

			1 - For State Registrar	State of	Marylan		artment rtificate			and M		jiener	2004	04	394
	Dhuaisi		1. Decedent's Name (First, Middle, Las.	1)							2. Date of Dea Month	th Day	Yeer	3. Time	of Death
	Physici /Medic		MERVIN CLAY I								JAN	24	2004	6:50	) A <sup>M</sup>
	Examin	er	4e. Fecility Name (If not institution, give	street and num	ber)		4b. City, T			f Death			County of Deeth		
			DEVLIN MANOR  5. Social Security Number 6. Se	J 1 -	7. Age (In yrs. I	ast hirthday	If Under 1		LAND If Under 2	24 Hrs.	8. Date of Birth		LLEGAN		
Н	Funeral Director			ÔM 2□F	80	Yrs.		Days	Hours	Min.	(Month, Day AUG 4 1	, Year)	Cou	place <i>(State</i> Intry) LAND	or r-oraign
	ס		Usual Residence of Decedent								100 4 1		IIII.	LIMIND	
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	
	Ba-f	Director	MARYLAND ALLEGAN	ζ	FR	OSTBUR									s 2 No
	with ti	E C	10e. Street and Number				10f. Zip 0				1	-	en of What Cou	ntry?	
	eath rs 23	erai	301 PARK STREET	12. Was Deced	tent Ever in U	S 13 V		2153		nin? (Snec	rify Yes or No.		J.S. 4. Race - Amer	can Indian	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f ehow other traumatic event, Its Medical Examiner must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 X Yes 1 Yes, Give Year or Da	ces? 2 ⊡ No 9 WW T		f Yes, specif	_	Specify:	, Puerto P	offy Yes or No- lican, etc.)		Black, White	etc.	
21215-0036	72 ho	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced	ient's Usual kind of work	Occupat	ion	of workin	2	16b. Kind	d of Business/Ir	ndustry	
2	within ene.	npie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	DO NOT use	retired)		OI WOIKIII					
	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)				MAINT			d- \$1	(First Manuals )	M-1d 0	TIRE		
Maryland	should be fi ind Mental F s marked of urnatic ever	To Be	RICHARD EDWARI	)S					18. Mother		(First, Middle, i RY MITC				
ary	2 should be and Mental is marked raumatic ev		19a. Informant's Name/Relationship (T	ype, Print)									Town, State, Zi	Code)	
	1 and 2 Health tem 27 i		HELEN EDWARDS / WI	LFE		discount of the last			T, FR	-	URG, MD	215	32		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 String 2 Cremation 3 1  4 Donation 5 Other (Specify,		tate C6	lace of Dispo emetery, cren STBURG	natory or oth	er place,		Da 1/2			ation - City or T STBURG ,		
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licens	5,	wer.		. Name and WERS 1				P.A.		MAIN TBURG,		532
T	11.0		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the death	. Do not ente	er the mode	of dying,	such as c	cardiac or	respiratory arre	est,		Approximately Interval Be	
	Physician		Immediate Cause (Final disease or condition	a		all	Thee	me	1	De				Onset and	
	/Medical Examiner		resulting in death)	Due to (o	or as a consequ	ience of):	1			,,,,					
	CAUTITIC!	_	Sequentially list conditions,	b. — Due to le	or as a cons	ann elle									
	ted nsit	Examiner	Cause (Disease or injury	Due 10 10	as a consum	ance of									
<u>,</u>	al-tra	xar	that initiated events resulting in death) Last	c. Due to (c	or as a consequ	ience of):									
8760,	cate be executed bhysician and the burial-transit			d											
9	tifical ng phy as th	Medi							71			-1			-
.O. Box	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal int at time of de	death 3	Ectopic pred Other (spec					23	d. Date of deliv Month	ery Day	Year
<u>α</u>	that the de ned by the a detached t		Part II. Other significant conditions co	ntributing to dea	ath but not resu	Iting in the ur	nderlying cau	se giver	in Part I.		23e. Did tob	acco use	contribute to t	he cause of	death?
ords,	w requires been signe should be	ted by	dysp	loges							1 □ Y€	s 2.	No 3∏Prol	oably 4	]Unknown
Vital Record	e la has	Completed	00								24a. Was a autops perform	y	death?	ppsy findings impletion of	available cause of
ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	Check only on		10 103	20110	
of <	Physic this ce al dire	2	1  Yes 2 <del>1 No</del>	Hospital: 1 🗆 In	patient 2 🗆 8	EP/Outpatien	t 3 DOA	Other	4 <del>2 N</del> ur	sing Hom	e 5 🗌 Reside	nce 6 (	Other (Specia	<b>'</b> y)	
ח	Attending Physicien: r death. sctor: After this certific: by the funeral director,	ë.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury		. Injury a Work?	·		d. Describe ho	w injury	occurred		
isio	ttend death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	200 01000	of twitter. At her		М		es 2□N		26 1				
Division	F 0 5 5	Certification;	4 Homicide determined	building	of Injury - At hor g, etc. (Specify	)	et, factory, o	пісе		20	City or Town		Number or Rur	N HOUIB NUI	nder,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	edicai (	29a. Certifier 1☐ Certifying Phy (Check only one) 2☐ Madical Exami	sician: To the bas nar: On the bas and manne	sis of examinati	viedge, death ion and/or inv	occurred at restigation, in	the time my opir	, date and nion, death	place, an	d due to the ca	iuse(s) ai ate and p	nd manner as s lace, and due to	tated. the cause(	s)
	To ti To ti comp	ž	29b. Signature and title of certifier	. 4			29c. l	icense i	number				signed (Month,		
,			· april	in h	2 N		De	5017.	565			fur.	18,2	004	
			30. Name and address of person who can A. J. Bollino,	Tr M T	922			Lghw	ay, L	∟aVa1	e, MD 2	1502			
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2 2004	gistrar Signat										
					A STATE OF THE STA	J. J. S.	and the	123							

DHMH 17 Rev 1/2001

ORIGINAL

04-00757 B.K.S JOHN FERREE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

N	FERREE		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment	of H	ealth a	and M	ental Hy	giene 2 (	004	04395
			Decedent's Name (First, Middle,	Last)						2. Date of D	eath		3. Time of Death
	Physici		John Edward	Ferree						JAN.	27, 200	Year )4	12:40 Pm
2	/Medic Examin		4a. Fecility Name (If not institution,		)	4b. City,	Town, or	Location of	of Death			y of Death	
	LXamiii		SACRED HEART HO	SPITAL		CUM	3ERL	AND			ALLI	EGANY	
	Funeral	-	5. Social Security Number 6		ge (In yrs. last birthday	If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth av Year)	9. Birth	place (State or Foreign
	Director		220-16-6891	1 <b>₾</b> M 2□F	80 Yrs.	Months	Days	Hours	IVIIF1.	Aug.	1923	Peni	nsylvania
	D		Usual Residence of Decedent		T							Т	
	urylar show	_	10a. State 10b. County		10c. City, Town or L								10d. Inside City Limits 1 ☐ Yes 2 No
	the Marylar 28s-f show notified at	ę,	MD Garre	tt	Frostburg	<u></u>							
	death with the Maryland rms 23a or 28a-f show frount be notified at	Funeral Director	10e. Street and Number			10f. Zip					10g. Citizen of	What Cou	intry?
	23a	la I	15625 National P				215				USA		
	em em	P	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe 1, Puerto l	cify Yes or N Rican, etc.)	0- 14. Ra Bla	ce - Amer Ick, White	ican Indian, , etc.
9	or l	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2	≥ <mark>K</mark> No	Specify:			Speci		
2-0036	d within 72 hours after death with the Maryla piene. r then "natural", or Items 23a or 28e-f shov the Madical Examitier is ust be notified at	Q P		Year or Dates:		edent's Usua	l Ossum	ation .			16b. Kind of E		hite
ç	nat	Completed	15. Decedent's (Specify only highest	grade completed)	(Giv	kind of wor DO NOT us	k done d	during mos	t of workii	ng	TOD. KING OF E	on all leasy li	loustry
7	withir ane. than	Ę.	Elementary/Secondary (0-12)	College (1-4or	5+)	:/Oper					Auto	Deale	rshin
N	Hygir Hygir Sther	ပို	12 17. Father's Name (First, Middle, Li	ast)	Owner	./ Oper	acor		r's Name	(First, Middle	e, Maiden Suma		.EUIIIP
yiand	S = 5	) Be	Marshall Ferree					Pear	-1 W	inters			
	es 1 and 2 should to Ment and Ment and Ment I item 27 is marked rother traumatic e	ရ	19a. Informant's Name/Relationshi		19b. Mail	ing Address	(Street 2				per, City or Town	, State, Zi	p Code)
Mar	d 2 s th ar t7 is trau		Tressia M. Ferre			-					.07;Fros		21532
	1 and Health tem 27		20a. Method of Disposition	e/ WITE	20b. Place of Disp cemetery, cre					ate	20c. Location		
ခြ	Pages nent of ant: If it ary or o		1 Bunal 2 ☐ Cremation 3		Grantsvi				an 30	0.2004	Grants	257111	a. MD
Baltimore,	mit. Pages 1 partment of I- portant: If ite y injury or ot		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Fune 2) Server D		· · · · · · · · · · · · · · · · · · ·						·	0 4 7 7 7	e, 11b
g	Deporting any in a		A Kend d	War all						es, P.			
			23a. Part1. Enter the disease, or conshock, of heart ailure. List o	omplications that sause	ed the death. Do not en	P.O.B	OX 2  B of dvin	75; ( g. such as	cardiac o	sville	arrest.	1536_	Approximate Interval Between
		1	shock, othean ailure. List o Immediate Cause (Final	nly one cause on each	12e.	1 - /		Λ _		0	A.c.	-	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a	Proserie	155701	Coz	100 h	rs w	len	Visea	.80	
	Examiner			Due to (or as	s a consequence of):								
		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence of):								
	ted	Examiner	Cause (Disease of Injury	1									
	xecu al-tra	Xar	that initiated events resulting in death) Last	C. Due to (or a	s a consequence of):							+	
/60,	ate be executed nysicien and he burial-transit	cal		d									
289	ficate physis the			0									
ROX	it the death certifica by the attending ph tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		-					23d. Da	ate of deliv	very
ň	death atte	cja	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		□Ectopic pr □ Other (sp					М	onth	Day Year
o.	the c by the achec	hysi	9 Unknown	9□ Unknown									
J.	law requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying c	ause give	en in Part I		23e. Did	tobacco use cor	tribute to	the cause of death?
Records,	quires n sign									1 🗆	Yes 2□No	3 🗌 Pro	bably 40Unknown
<u></u>	w require been sign should b	Completed								24a. Wa	s an 24b.	Were aut	opsy findings available
E E	The la	E C									ormed?	prior to co death?	ompletion of cause of
Vital			25. Was case referred to medical					26 Place	of Death	(Check only	2 No	105	2   140
	ysicie is cert direct	To Be	examiner? 1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2XXER/Outpatie	ent 3 DC	A Oth	ar.			idence 6 □Ot	her /Speci	ifv)
ō	Attending Physicien: if death. ector: After this certific by the funeral director,		27. Manner of Death	28a. Date of In	urv 28b. Time		8c. Injury Work				how injury occu		·//
0	afing : Afte	ig ig	Natural 5 ☐ Pending 2 ☐ Accident investiga		ay Year) Injury	м		Yes 2	No				
Division	i or Attend after death Director: ,	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Place of II	njury - At home, farm, s	treet, factory	, office		- 1	28f. Location	(Street and Num	ber or Rui	ral Route Number,
á	al or A s after Il Direct Id in by	Certification:	4   Horricide	building, e	itc. (Specify)					Ony or re	MII, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by			Physician: To the bes xaminer: On the basis	t of my knowledge, dea	th occurred	at the tin	ne, date an	d place, a	and due to the	cause(s) and m	anner as	stated.
	he He n 24 he Fu	Medical	(Check only 2X) Medical E	and manner s	or examination and/or i	nvestigation,	in my o	pinion, dea	un occum	ed at the time	, date and place	, and due	to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	0	$\bigcirc$	290		number			29d. Date sign		
			1/ 1/1	rhem			0.0	.M.E			JAN.	. 28	, 2004
			30 Name and odreas of person w	no completed cause of	death (Item 23a) (Type	, Print)					· <u>-</u>		
		1	1- Ut KON (	NEKEN		n Str	eet,	Balt	imor	e, Mar	yland 21	L201	
	Sta		31. Date filed (Month, Day, Year)		trar's Signature	Specia							
	Regist	rar	JAN 2	9 2004	Even D.								

			For State Registrar	State of	Marylan		artment rtificate					giene leg. No.2	104	04	396
	· · ·		1. Decedent's Name (First, Middl	e, Last)						2.	Date of Dea Month	th Day	Year	3. Time	of Death
	Physici Medio/		Albert	John	FLE	MING				J	anuary			4:25	Р м
	Examir		4a. Facility Name (If not institution	n, give street and num	nber)		4b. City, T	Town, or I	Location o	of Death		4c. Coun	ty of Death		
			1010 Bittinge	r Road				9	Swant	on			Garr	ett	
	Funeral		5. Social Security Number	6. Sex 1 △ M 2 □ F	7. Age (In yrs.		If Under 1 Months	1 Year Days	If Under:	Min.	Date of Birth (Month, Day	(Year)	9. Birth	place (State ntry) rylanc	or Foreign
	Director		213503112	TEM ZOP	5	7 Yrs.				Se	ept. 2		Ma	rýlano	1
	pur M		Usual Residence of Decedent  10a, State  10b, County		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits
	sho	5		arrett		,,		want	on				1		s 2⊠No
	the N	ect	MD G	ariett			10f. Zip (					I0g. Citizen of	Mhat Cau		
	with a	늅		D - 1			101. Zip (		01550	`		rog. Citizen o		-	
	s 23	Funeral Director	1010 Bittinger		dent Ever in U	S 12	Was Dood		21550		y Ves or No-	14 Ps	US Oce - Ameri	can Indian,	
	lter d	Ş	1 ☐ Never Married 2 [X] Mar	Armed For	ces?	1			, Mexican	, Puerto Ric	y Yes or No- an, etc.)	BI	ack, White		
36	Ir, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Giv	θ		1 ☐ Yes 2	ĭ No	Specify:			Spec	ity: Wh	nite	
<b>ŏ</b>	thou sture	ed	15. Deceden	it's Education		16a. Dece	dent's Usual	Occupat	tion			16b, Kind of	Business/Ir	ndustry	
5	n 77	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)	Apr. E. I.	(Give	kind of work DO NOT use	k done du e retired)	uring most	t of working					
212	T the	E	Elementary/Secondary (0-12)	College (1	-401 J+)		Mainte	enano	се Ор	erato	r	Paper	Manuf	actur	er
ਰੂ	othe ent,	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name <i>(F</i>	irst, Middle,	Maiden Suma	me)		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28a-f show enty injury or other treumatic event. The Medical Examinating the notified at Once.	To B	Joseph	Charles		FLEMIN	G		Elia	zabeth	Ma	agdaler	ıe	WILHE	LM
ary	shound N		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street ar	nd Numbe	or or Rural R	loute Number	r, City or Tow	n, State, Zij	o Code)	
Σ	alth a		Linda L. Flemi	ng/wife		1010	Bitt:	inge	r Roa	ad, Sw	anton,	Md. 2	1561		
ē,	item item		20a. Method of Disposition			Place of Dispo	sition (Name	e of her place	)	Date	•	20c. Location	- City or T	own, State	
Ë	Page lent c nt: If ry or		1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		state	erbeir	•			2/1/0	4	Swanto	n. Ma	rvlan	d
=	arta sorta inju		21. Signature of Funeral Service	1-1	1000							ineral			
ă	Ped Fig	1	> Biellen F	Mund								l, Md.		)	
	Pnysician /Medical Examiner		23a. Part1. Enter the diseash, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	aused the deat ach line. IO BL or as a conseq	AST			, such as	cardiac or re	espirato <i>r</i> y arr	est,		Approximation interval Be Onset and	tween Death
.8760,	Examiner and transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (	or as a conseq		,								
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d	death 3	Ectopic pre Other (spe						ate of deliv	ery Day	Year
rds, P	w requires that been signed to should be deta	by	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	nderlying ca	use giver	n in Part I.		23e. Did to	bacco use cor es 2000 No		he cause of bably 4	
Division of Vital Records,	To the Hospitel or Attending Physician: The law re within 24 hours after death. To the Funerel Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Completed									24a. Was a autops perform			opsy finding impletion of	
<u> </u>	ician: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?	I				_			check only or	ne)			
<u> </u>	Physician: r this certifica ral director, p	ပ္	1 ☐ Yes 2 No	_		ER/Outpatier	t 3 DOA	Other	4 □ Nu	rsing Home	5 X Reside	ence 6 🗆 Ot	her (Speci	M HOS	PCE
0	ding P n. After ti funera		27. Manner of Death  1 ★Natural 5 ☐ Pendir	28a. Date o	f Injury h, Day Year)	28b. Time o Injury	28	c. Injury	at ?	28d	l. Describe ho	ow injury occu	rred		
0	Attending it death.	ati	2 ☐ Accident investi	gation			М	1 🗆 Y	es 2 🗆 1						
Š	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 200. Place	of Injury · At he g, etc. (Specif	ome, farm, sti y)	eet, factory,	office		28f.	Location (St City or Town	treet and Nun n. State)	ber or Run	al Route Nu	mber,
	rs after or all bir led in	Ce													
	tosp thon unei	edical	(Check only 2 Medical	ng Physician: To the Examiner: On the ba	sis of examina	wledge, deat	occurred a	t the time	e, date and	d place, and th occurred	due to the cat the time. d	ause(s) and mate and place	anner as s	stated. o the cause	(s)
	To the Hospitel within 24 hours a To the Funeral completely filled	Medi	one)	and mann	er stated.	2.5	-				-				
	5 Miles	-	29b. Signature and title of certifie		201	200	290.	License			2	9d. Date sign		⊔ay, rear)	
			Jane 2	Januar	nue	soft.	4	Н2	6154			1/30	7/04		
	2		30. Name and address of person						_		V.1	21550			
	O		Paul Daniel M:			Volf Ac	eres D	rive	, 0al	kLand:	Md. 2	21550			
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 3 0	0001	egistrar's Signa	ture	well								

			For State Registrar	State o	of Maryla	•	artment <i>rtificate</i>				Reg. No.	04	04397
П	Physici	an	1. Decedent's Name (First, Middle,		DIEND					2. Date of De.	Day	Year	3. Time of Death
	/Medic	al	CHARLOTTE ELIZ  4a. Facility Name (If not institution.		MIEND		4b. City. To	wn, or Local	tion of D	JANUARY	4c. County	004 of Deatl	11:00 PM
н	Examin	er	111 EAST OAK ST		,		OAKL				GARRE	тт	
	Funeral			S. Sex		s. last birthday)	If Under 1 Months	Year If Ur Days Hou	nder 24 urs N	Min. (Month. Da	h v. Year)	9. Birtl	hplace (State or Foreign untry)
	Director		578-42-7412 Usual Residence of Decedent	1 ☐ M 2 💢 F	73	Yrs.				MAR. 19	9, 1930	_MAI	RYLAND
	land ow		10a. State 10b. County	<del></del>	10c. 0	City, Town or Lo	ocation						10d. Inside City Limits
	Many	호	MD GARRE	TT		OAKLAN	D						1 X Yes 2 □ No
	th the or 28a	Director	10e. Street and Number				10f. Zip C	ode			10g. Citizen of V	Vhat Co	untry?
	ath wi		111 EAST OAK ST					550			USA		in testing
	ltems	Funerai	11. Marital Status  1 ☐ Never Married 2 ☒ Marrie	Armed Fo		U.S. 13.	Was Deceder If Yes, specifi	nt of Hispanio Cuban, Me	c Origin' xican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Hac	e - Ame k, White	rican Indían, e, etc.
936	2 hours after death with the Marylan eturel', or Items 23e or 28e-1 show ical Examiner must be nutified at	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes 2]	No Spe	ecify:		Specify	" W	HITE
21215-0036	72 hours after death with the Maryland neturel; or Items 23s or 28s-f show dical Examiner must be notified at	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual	done durina	most of	working	16b. Kind of Bu	isiness/	Industry
121	d within giene. ir than *	mpje	Elementary/Secondary (0-12)	College (	1-4or 5+)		<i>DO NOT u</i> se RATORY		NTC(	ΛP	HOSPIT	ΑТ	
	be filed v tal Hygie d other t svent, II		17. Father's Name (First, Middle, La			LABO	KATOKI			Name (First, Middle,			
Maryland		To Be	SCOTT WOTR	ING SH	IRER			В	BEAT	RICE	A	SHBY	Y
ary	2 should I and Meni Is marker eumatic		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address (S	Street and No	umb <b>e</b> r o	r Rural Route Numbe	er, City or Town,	State, Z	Zip Code)
	and ealth m 27 har tr	1 33	WAYNE CALLIS -	SON	201	408 Place of Dispo	ROANO:		M'	I. LAKE PA			
Baltimore,	00		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3		State	cemetery, cre	matory or oth	er place)	1 1		20c. Location -		
∄			* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		0	AKLAND 2	CEMETE  2. Name and			31/04			ARYLAND
Ba	permit. Departr Importa any inj		Esterit My	Quet	MO(					ME - OAKL	BOX 243 AND, MD		50
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that	caused the de	ath. Do not en	ter the mode	of dying, suc	h as car	diac or respiratory ar	rest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition			cardia1	infar	ction					Onset and Death immediate
и	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):							
		ē	Sequentially list conditions,	b. Cor Due to	onary or as a cons	artery	diseas	e					years
	xecuted and Il-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c dia	betes	mellitu	.s						years
oʻ	e exection and and and and and and and and and an		resulting in death) Last		(or as a conse	equence of):							
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medical		d									
9 X	leath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, ou	tcome of preg	nancy					23d. Dat	e of deli	iverv
Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	4☐Preg	birth 2∏Fe nantattime of		⊒Ectopic preg ⊒ Other (s <i>pec</i>				Moi		Day Year
P.O.	it the d by the tached	hys	9 Unknown	9□ Unkr	iown								
	res that igned b	by P	Part II. Other significant condition	s contributing to a	leath but not re	esulting in the u	inderlying cau	se given in F	Part I.			pibrute to 3 ⊟ Pro	the cause of death?
Vital Records,	w require been si should t	Completed						· · · · · · · · · · · · · · · · · · ·			S		
Rec	has t	mp						<del> </del>		24a. Was autop perfo	rmed?	prior to d death?	topsy findings available completion of cause of
<u> </u>		ပို	25. Was case referred to medical					26 F	Place of	1 ☐ Yes  Death (Check only o		☐Yes	2 🗆 No
<u> </u>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other			dence 6 Oth	er (Spec	cify)
n of	ding Ph h. After th funeral		27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury		. Injury at Work?		28d. Describe h	now injury occurr	ed	
sio	Attending r death. ector: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	ition	a at Imirrar At	hama (a at	M	1 ☐ Yes	2 □ No	296 Location /6	Street and Numb	or or Pu	ıral Route Number,
Division	- e - c	Certification:	4 ☐ Homicide determin	ed 289. Flace build	ling, etc. (Spec	home, farm, st cify)	reet, lactory, t	onice		City or Tox	vn, State)	31 OI 110	mai i lobie Number,
	Hospital		29a. Certifier	Physicien: To the	e best of my k	nowledge, deat	h occurred at	the time, dat	te and p	lace, and due to the	cause(s) and ma	nner as	stated.
	To the Hospital c within 24 hours at To the Funeral D completely filled in	ledicai	one)	and mar	ner stated.	nation and/or in	ivestigation, ir	n my opinion,	, death c	occurred at the time,			
	with To	Σ	29b. Signature and title of certifier				290.	D ( )	33	2	29d. Date signed		
	in		30. Name and address of person w	ho completed carr	se of death (It	am 23a) /Type	Print)	,			01/30/2	<u> 2004</u>	
	10		Thomas G. Jol			1 N. Fo		Street	0 <i>a</i>	akland, MD	21550		
	Sta		31. Date filed (Month, Day, Year)		gistrar's Sig								
	Registi	rar	JAN 3 0	2004	Septem 1	15- 16	seeds.						

	•	- For State Registrar Amended#23	State of Mab						and M		giene Reg. No.	200	4 04	39
Physicia /Medica	al	Decedent's Neme (First, Middle, Las     MARJORIE KATH     A. Facility Name (If not institution, give	ERINE F	ELICE		4h Cih	Town or	Location o	of Doath	2. Date of De Month JAN.	28 Day	200	4 10:4	
Funeral		SHADY GROVE NU 5. Social Security Number 6. Se	JRSING H	OME e (in yrs. las 90	it birthday) Yrs.		CKV	ILLE If Under		8. Date of Bir		MONT	GOMERY  Birthplace (State of Country)	or Foreigi
Director  one of the partial of the	or	Usual Residence of Decedent  10a. State  10b. County	MEDV	10c. City,	Town or Lo					TDD (			NY  10d. Inside C  1 □ Yes	' /
h with the h	al Director	MD MONTGO  10e. Street and Number  9701 MEDICAL CE			CKVI	10f. Zip	Code	0			10g. Citiz	en of What	•	
urs a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		i	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	city Yes or No Rican, etc.)	1	4. Race - Al Black, W Specify: W		***************************************
filed within 72 ha Hygiene. Ather then "netur Int. he Wad cal	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 0			(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	turina most	t of workir	ng		d of Busine		
should be filed and Mental Hygis marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) FRANCIS DEMARI			405 14 77		(2)	MAR	GARE	(First, Middle,	WIN	,		
		19a. Informant's Name/Relationship (7. MARGUERITE JEFF 20a. Method of Disposition	FRIES/DA	UGHTE	R 17		HUG:	HES 1	RD.,	POOL ete	ESVI	LLE,		337
permit. Peges 1 a Department of He importent: If item eny injury or othe		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens	)		O ME	EMORI  2. Name an	AL d Addres	GAR. ss of Facility UNER	AL H	/2004 IOME ENESVI			HILLS,	FI
	dical Examiner	23a. Pan1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each li	a consequen	stiv					r respiratory a		72	Approximatinterval Bet Onset and	Death
that the death certifica ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3[	Ectopic pr					2	3d. Date of o	•	Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions of	entributing to death b	ut not resulti	ng in the u	nderlying c	ause give	en in Part I.		23e. Did t		,	to the cause of c	
	Completed									1 Yes	osy ormed? 2 X No	24b. Were prior to death 1 \( \textsquare \text{Y} \)		available ause of
S &	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 25. No	Hospital: 1 ☐ inpatie	ent 2 EF	VOutpatier	nt 3 DO	Othe	200		(Check only only one 5 ☐ Residue)		□Other (S)	pecify)	
Jing After fune	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Surcide 4 Homicide  2 Natural 5 Pending investigation 6 Could not be determined	286. Place of Inj	y Year)	8b. Time o Injury e, farm, str	М		yat (? Yes 2□f	No	28f. Location ( City or Tox	Street and		Rural Route Num	iber,
To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Co	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	rsicien: To the best iner: On the basis of and manner sta	f examination	edge, deat n and/or in	h occurred vestigation.	at the tim , in my of	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) a	and manner place, and d	as stated. lue to the cause(s	s)
withir To th comp	Me	29b. Signature and title of certifier	~	<b>1</b>	20) 7		_	66	52			_	28, 2	000
5 Stat		30. Name and address of person who of Mathlew 31. Date filed (Month, Day, Year)	offen	r's Signatur	M	99	01	Me	die	al Cer	ste-	Oc,	28,2	ilb/

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

JAN 2 9 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Janaury 23, 2004 8:45  $A^{M}$ DOROTHY FORD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Hospital Ctr. Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5 Social Security Number 6 Sex **Funeral** 1 □ M 2 1 → F June 4,1927 Director Virginia 578-30-3549 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic event. If a Medical Example must be retilized at Landover 1 X Yes 2 No Prince George's MD Director 10g. Cilizen of Whal Country? 10f. Zip Code 10e. Street and Number 29785 USA 7106 Mahogany Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, elc. 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Beautician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jessie (last name unknown) Joseph Essex ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 P Street, SE Wash. D.C. 20020 Pages 1 and 2 Beatrice Proctor/Sister Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or Cedar Hill Cemetery 02/03/2004 Suitland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sun ture of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. pnce 4111 Pennsylvania Ave., Suitland, MD 20746 t 00 2 a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Recurrent Mate Cause (Final Voulo aclas obillation days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner marcho hene Cascle nugi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulling in death) Last Due to (or as a consequence of): Examiner 4e aux and I-transit death certificate be executed Due to (or as a consequence of): the attending physicien a hed for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 Cardiopeous Shock sulymeers brail 1 Yes 2 No 3 Probably 4 Mnknown Completed peen acute 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Reproatori 24a. Was an page 2 s has schal Drabetesmellities bronce 1∐ Yes 2 No certificate of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Atter 5 Pending investigation Division 1 Natural Injury or Attending 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide after To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24720 01/23/04 unlas RAVINDER K. RUSTAGI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANDOVER CHEVERLY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 Registrar

			1 - For State Registrar		ryland / Depa		lealth and	Mental Hygi	•	04 04401
>	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Lass     Jani     4a. Fecility Name (If not institution, give     Glade Valley No	street and number)	Mae ter	Fir 4b. City, Town, or Wall			Day 200 4c. County of	
de	Funeral Director		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Y#1916	e. Birthplace (State or Foreign
	72 hours after death with the Maryland rhatural; or Items 23s or 28s-f show dical Examinat her multiped at	Funeral Director	10a. State 10b. County Maryland Frede  10e. Street and Number 6014 Linganore Ro		10c. City, Town or Lo	Frederic	k 21701	10	g. Citizen of Wh U.S	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat injury or other traumatic event, the Medical Examinat injury or other traumatic event, the Medical Examinat injury or other profiled at 2008.	by	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc. White
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired naker	during most of wo	rking 1 me (First, Middle, M	Own Ho	ome
laryland	should be f and Mental b is marked of sumatic ever	To Be	Charles Powell  19a. Informant's Name/Relationship (1) Leslie F. Markoe/	voe. Print)	19b. Mailir 51 52	ng Address (Street	Sara	h Winston		are, Zip Code) Land 21754
Baltimore, M	Pages 1 and 3 nent of Health int: If item 27 iry or other tri		20a. Method of Disposition  1 □ Burial 2 🎗 Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Dispo Smithsbuff	sition (Name of		Date 2	Oc. Location - Ci	burg, Maryland
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funerat Service Licen  23a. Part 1. Enter the disease, or compshock, or heart failure. List only	l Home <del>rederic</del>	k.⊤MD 21701					
760,	Physician /Medical Examiner  bhysician and physician and street physicia	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Seve  Due to (or as a  b. Due to (or as a	consequence of):  consequence of):	mic p	bstruct	in ling	Disca	Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate tee has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ñ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at the 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
Records, P.	w requires that t been signed by should be detat	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	4.	2 □ No 3	ute to the cause of death?  Probably 4 Unknown  re autopsy findings available
Vital Re		Be Completed	25. Was case referred to medical examiner?				26. Place of Dec	autopsy perform	prid dea No 1	or to completion of cause of ath? I Yes 2 No
Division of V	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	2	1 Yes 2 Vivo  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien  28a. Date of Injury  (Month, Day	28b. Time of	28c. Injun Work	at Nursing F	fome 5 Residen 28d. Describe how		
Divis	Hospitel or Atte 24 hours after de Funeral Directe tely filled in by ti	Certification:	3 Suicide 6 Could not be determined	building, etc.				City or Town,	State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier (Check only one)  2 Medical Examone)	ysician: To the best o liner: On the basis of and manner stat	examination and/or in	vestigation, in my of	pinion, death occi	irred at the time, dat	e and place, and	er as stated. d due to the cause(s)  Month, Day, Year)
	7 × 0 0		<b>)</b> St					!		
	b			andi a			ic Hous	e Are,	Rede	rich, kill)
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 2 2004	32. Hegistra	r's Signature					

		riease			epartment of h			_	
		For State Registrar	State of Mary		Certificate of		ind montain,	Reg. No. 201	04 04402
Physici	an.	1. Decedent's Name (First, Middle, Last					2. Date of D Month		3. Time of Death
/Medi	cal	Virginia May  4a. Facility Name (If not institution, give			4b. City, Town,	or Location o	of Death	4c. County o	7 3.72
Examir	ner	Sirred Hear	1 . 1 . 1	ral	C120		and	Alle	
Funeral		5. Social Security Number 6. Se	x 7. Åge (/	In yrs. last birth	Months   Days	If Under		rth	9. Birthplace (State or Foreign Country) WV
Director		236-03-2034 15 Usual Residence of Decedent	]M 21X F	84 Y	rs.		May 1	,1919	WV
yland sow		10a. State 10b. County	10	0c. City, Town	or Location				10d. Inside City Limits
e Mar	ctor	WV Minera	a1	Keyse					1X Yes 2 □ No
be filed within 72 hours after death with the Maryland lat Hygiene. Id Hygiene. Id other then "natural", or Items 23e or 28e-f ehow event, the Madical Examiner must be natilised at	Funeral Director	10e. Street and Number 10 N. Church S	Street		10f. Zip Code 2672	26		10g. Citizen of W	
death ms 23	neral	11. Marital Status	12. Was Decedent Eve	er in U.S.			gin? (Specify Yes or N i, Puerto Rican, etc.)		- American Indian,
after or Its	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2X No		i, ruello nicari, etc.)	Specify:	, White, etc.
hours tural',	ed by	3 ☐Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a	Decedent's Usual Occu	pation		16b. Kind of Bus	White siness/Industry
nin 72	Completed	(Specify only highest grad	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire	during mosi	t of working		,
ed with ygiene t, the	Com	Elementary/Secondary (0-12)		F	lomemaker	T			Home
Lal y latter & 1.4. 2 should be filed within and Mental Hygiene. is marked other then aumatic event, the Manuel Control of the Manue	Be	17. Father's Name (First, Middle, Last)  Frank Brown					or's Name <i>(First, Middle</i> rriett El		
should nd Me mark imatic	2	19a. Informant's Name/Relationship (T)	ype, Print)	19b.	Mailing Address (Stree				
and 2 allth a allth a 27 io		Edward Fisher			0 N. Chur		of Carlotte Territory		
or oth	10	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State		Disposition (Name of crematory or other pla		Date		City or Town, State
position of the property of the permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then enty injury or other traumatic event, the Mance.		<ul><li>4 □ Donation 5 □ Other (Specify,</li><li>21. Signature of Funeral Service Licens</li></ul>		POTOI	nac Memori  22. Name and Addr	1	2/09/04	Keyser	, WV
Dermi Department Timpo Tim Timpo Timpo Timpo Timpo Timpo Timpo Timpo Timpo Timpo Tim		Harld Down	notance.	1	Markwood	Fune	eral Home , Keyser,	WW 267	26
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause the ne cause on each line.	e death. Do n	ot enter the mode of dy	ing, such as	cardiac or respiratory	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a	enal	Fallu	re			Onset and Death Zwelley
/Medical Examiner		resulting in dealiny	Due to (or as a o	consequence	Parlui	cinco	1111		6wanth
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	b. Due to (or as a c	consequence of			777		Ortano d
scuted ind transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c						
te be executed ysician and be burial-transit	calEx	resulting in coatin, task	Due to (or as a c	consequ <i>e</i> nce c	π).				
COIGS, F.O. BOX 66/00, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi			d						
th cert	Physician/Medi	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		3 ☐Ectopic pregnanc	су		23d. Date Mon	of delivery th Day Year
the atter	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tin 9□ Unknown	ne of death	5 Other (specify)			Mich	ar ouy rou.
requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions co	ontributing to death but i	not resulting in	the underlying cause g	ven in Part I	. 23e. Did	tobacco use contri	bute to the cause of death?
w requires been sign should be	ed by						1	Yes 2□No	3 ☐ Probably 4 ☐ Unknown
tawre as be	Completed						24a. Wa	opsv pr	fere autopsy findings available nor to completion of cause of
The The cete has	Con						1 ☐ Yes	2 No 1	eath? □ Yes 2□ No
OT VICAL Physicien: 1 this certificel ral director, p	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Ho	Hospital:	2 ☐ ER/Out	patient 3 DOA	her:	of Death Check only irsing Home 5  Res		r (Spacify)
On of Vital Red ding Physicien: The lav h. Alter this certificete has funeral director. page 2	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Y		ime of 28c. Inju			how injury occurre	
SIOF endin eath. or: All	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 10	Yes 2			2 12 1 2 2
DIVISION  I or Attending after death. Director: Afte	Certification;	4 Homicide determined	28 <i>e.</i> Place of Injury building, etc.	r - At home, far (Specify)	m, street, factory, office			(Street and Numbe own, State)	r or Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funeral completely filled in by the funeral process.	alC		ysician: To the best of						
the Ho in 24 the Fu	ledical	one)	iner: On the basis of early and manner state	id.			un occurred at the time		
To To	Σ	29b. Signature and title of certifier	1/1/	11/11	290. Licer	ise number	><-	7 /	(Month, Day, Year)
2		30. Name and address of person who d	completed cause of dea	th (Item 23a) (	Type, Print)	, ) /	2 1	1	, ,
9		Thomas E	Chan	1/11	D 9/25	eton	0-641	mberk	W/MD
St Regist	ate	31. Date filed (Month, Day, Year) FEB 1 2 2004	El .	s Signature	heales				

			1 - For State Registrar		State of	Marylan	•	artmer			and M	lental Hy	giene Reg. No.	004	04403
			Decedent's Name (First)	Middle, La	ist)						-	2. Date of De	ath		3. Time of Death
	Physici /Medio		Lewis Edw	ard	Gittere							January	7 23,	2004	7:24 P M
	Examir		4a. Facility Name (If not in:			ber)		4b. City,	Town, or	Location o	of Death			ounty of Deat	
			Garrett Co.	Memor	ial Hosp	ital		Oak1	and,				Ga	rrett	
	Funeral		5. Social Security Number			. Age (In yrs.	last birthday)	If Under	r 1 Year_	If Under 2		8. Date of Bird	h	9. Birt	hplace (State or Foreign
	Director		217-14-3489		1₫M 2□F	83	Yrs.	Months	Days	Hours	Min.	Month, Da Jan。21			vland
	2		Usual Residence of Deced												
	thow thou	_	10a. State 10b. 6	County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	e Me	Director	MD Ga	rrett		Fri	endsvi	lle							1 ☐ Yes 2 No
	er 2	o ic	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What Co	untry?
,	23a	<u>a</u>	210 Blooming	Rose	Road					21531				USA	
	r deg	Funeral	11. Marital Status		12. Was Deced	ces?	.S. 13.	Was Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 14	. Race - Ame Black, White	
36	or in		1 Never Married 2		ty Types 2	2 □ No		1 ☐ Yes		Specify:				pecify:	
8	nour	d by	3 Widowed 4 □ Di		Year or Da	tesWW2								Whi	
Maryland 21215-0036	iled within 72 hours after death with the Maryland Hygiene. Hygiene. then "neturel", or items 23s or 28e-f show ant, the Maulical Examinar must be nutified at	Completed		cedent's E highest gr	ducation ade completed)		16a. Deced	ient's Usu: kind of wo DO NOT u	rk done d	lurina most	of worki	ng	16b. Kind	of Business/	Industry
2	then in		Elementary/Secondary (	0-12)	College (1-	4or 5+)		wrigh		,			C	onstru	ation
7	Hygid Ther nt.		17. Father's Name (First, M	Aiddle Last	·)		LITTT	wr 191		18 Mother	r's Name	(First, Middle,			CTOH
an	ould be Mental arked o	Be													
2	should ind Men inarke imarke	၉	William Leon  19a. Informant's Name/Re				10h Mailir	a Address	(Street a			latherir I Route Numbe			Via Codo)
Z Z	C1 (0 == 0)														
6	1 and 1 Health em 27 Ither tr		Roger L. Git  20a. Method of Disposition		son	20b. P	lace of Dispo	sition (Nar	ne of			riends		MD ition - City or	21531 Town State
و	if it		1 ☑ Burial 2 ☐ Crem	ation 3		tate	emetery, crer	natory or c	ther place			-314			
Baltimore,	rtmer rtent njury		° 4 □ Donation 5 □ O			Fri	end Ce					7,2004		dsvill	e, MD
Bal	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral S	elvice Lice	nsee		N		Fun	eral	Home	s, P.A.	•		
			23a. Part1. Enter the dise	yn	1 le	em		.O. B	ox 2	75; G	rant	sville,	MD	21536	<b>*</b>
			snock, or heart failure	e. List only	one cause on ea	ch line.	n. Do not ent	er the mod	e or dying	, such as c	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)		a Sta	iph a	weil	5 5	ept	'cem	ia				week
	/Medical Examiner		resulting in dealtry	•	Due to (o	r as a conseq	uence of):	1	0						
		_	Sequentially list conditions		b	TIONI	C res	ial	ta	ilu	re				years
-	sit ed	Examiner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	°₹	Due to (o	ras a consequ	Dence on:		2						
	and and I-tran	хап	that initiated events resulting in death) Last	1	c. Due to (o	r as a consequence	uence of):	ype	1						years
8760,	ficate be executed physician and is the burial-transit	<u>=</u>			220 10 (0	. 45 4 55/1504	aorioo (ii).	0 1							V
84	physic the	dlcal		•	_ d			·							
9 : X	w requires that the death certilic been signed by the attending p should be detached for use as	Completed by Physician/Me	IF FEMALE:		23c. If yes, outco	ome of pregna	DOV.								
Вох	atten atten for us	lan	23b. Was decedent pregna in the past 12 months		1☐Live bir	th 2 ☐ Fetal nt at time of de	Ideath 3□	Ectopic pr					230	<ol> <li>Date of delification</li> <li>Month</li> </ol>	very Day Year
о. Э	the d	yslc	1 □ Yes 2 □ No 9 □ Unknown		9☐ Unknov		Balli 5	Other (sp	өспу)						
۵.	that the	F.	Part II. Other significant c	onditions	contributing to dea	ith but not resi	ulting in the ur	nderlying c	ause nive	n in Part I		23e. Did to	bacco use	contribute to	the cause of death?
Records,	sign d be	5	Carraga Luc h	mt 1	Cailere	mit	0 00	2,00	1 0	210 14	Dust	1 1 Y			bably 4 Unknown
Ö	requ been shoul	ete	5 1/2 0	1	1	h.			ya	1					
ဋ္ဌ	e law has je 2 s	ld m	DIVE Sinu	- sy	malram	- My	grent	ens	ion	/		24a. Was a autop perfor	an sy	24b. Were au prior to c death?	topsy findings available ompletion of cause of
<u>a</u>	cate	S			<del></del> :								2 XNo		2 No
Division of Vital	Iclar certif ector	Be	25. Was case referred to n examiner?	nedical	Hospital:				Otho	-		(Check only of			
o	this aldir	70	1 Yes 2 No 27. Manner of Death		28a. Date of		ER/Outpatien 28b. Time of			4 LI NUI		ne 5 Resid			ify)
ב	After funer	lo	1 SNatural 5 □	ending	(Month	Day Year)	Injury	M	8c. Injury Work			8d. Describe h	ow injury o	ccurred	
Sic	death.	Certification:	3 ☐ Suicide 6 ☐	nvestigation Could not b	e One Diese	f Injury - At ho	one form sta			es 2 🔲 N		Of Leasting (F	************	(	-18
<u>≥</u>	or A after Direct in by	iti	4 Homicide	determined	building	g, etc. (Specify	/)	eet, ractory	, OHICE		-	City or Tow		vumber or mu.	ral Route Number,
	ours ours ieral filled		29a. Certifier	rtifyina Ph	nysician: To the b	est of my know	wledge death	Occiored.	at the time	a data and	l place =	nd due to the	101100/51 5	d manager :	atetod
-	to the Hospital of Attending Physician: The law requires that the death certilicate be executed within 54 hours after death. The 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Me	dical Exa	miner: On the bas	is of examinat	tion and/or inv	estigation,	in my opi	inion, death	h occurre	d at the time, o	ause(s) ar late and pl	ace, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of	certifier 1	- 0 1	/		290	. License	number		2	29d. Date s	igned (Month	, Day, Year) ;
,	- 3 <del>-</del> ŏ		> Margo	VI	UX	und	W		7	7//	E ,_		1	1221	mal
		1	30 Name and address	oreco unha	completed serve	of death (lin-	23a) /T	Drine)	U	alp	20		1/	23/1	007
	124	12	30. Name and address of p	1 .	Completed cause	Ol death (item	2/17-/2	for4	141	itial	1	, O.	11/1	11.	4/ 2/537
	Sta		31. Date filed (Month, Day,	Year)	32. Rec	gistrare Signa	ture	un	wy	11130	no al	Ten	1-164	-/	10 2.00
	Registr			IAN 9		100 mg . ca	. As	A so	(R)						

TERE

RES	SA G. G		TAFSON #2 State of Maryland #1 State Amended Item#23a, 27, 28a-f, Per Mi	/ Depa	artment of l	Health ar <b>B</b> eath	nd Mental H	ygiene 2 (	004	10/12/20	401
	7.5		Decedent's Name (First, Middle, Last)				2. Date of D	eath	Year	3. Time o	of Death
	Physici		Teresa Gail Gustafson				JAN.	29, 20	004	0927	АМ
100	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4603 HANOVER PIKE		4b. City, Town, o MANCH		Death	1	ty of Death		
	Funeral Director		5. Social Security Number 225-15-9129 6. Sex 1 □ M 2√2 F 41	birthday) Yrs.	If Under 1 Year Months Days		Min (Month, L	irth <i>Bay, Year)</i> 6, 1962	9. Birth Cou Vir	place (State intry) ginia	or Foreign
	pu *		Usual Residence of Decedent           10a. State         10b. County         10c. City, T	own or La	cation				1	10d. Inside C	City Limits
	aho	5				Manches	ster		4		s 2/1 No
	28a-f	Director	Maryland Carroll  10e. Street and Number		10f. Zip Code			10g. Citizen of	f What Cou	intry?	
	with	<u>a</u>	4603 Hanover Pike			2110	)2		USA		
	ns 2:	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of I	Hispanic Origi	n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Ra		ican Indian,	
Maryland 21215-0036	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f ahow injury or other traumatic event, the Medical Examinar must be routified at injury or other traumatic event, the Medical Examinar must be routified at 8a.	by Fun	Armed Forces?  1 Never Married 2 Narried   1 Yes 2 No If Yes, Give Year or Dates:		fYes, specify Cub 1 ☐ Yes 2 ☐XNo		Puerto Hican, etc.)	Spec	ack, White	white	
ŏ	2 hot	ted	15. Decedent's Education	6a. Deced	dent's Usual Occu	pation	of working	16b. Kind of	Business/l	ndustry	
215	e.	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done		a working	Elec	troni	.c Sale	2 <b>C</b>
2	filed withi Hygiene. other than	Completed	12		Office M					.c bare	
nd	be fift atal H od oth	Be	17. Father's Name (First, Middle, Last)				s Name (First, Midd		ame)		
₹ Z	and Mental	2	Jerry Alan Nichols	105 Mailie	a Address /Ctros	-	M. Jacks		n State 7	in Code)	
Mai	12 st h and 7 is n traun		G. Eric Gustafson, husband				Mancheste			p 000e)	
	1 and Health em 27				sition (Name of matory or other pla		Date	20c. Location		own, State	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☐ Burial 22 Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  Cal	rroll	Cremati	ons 0	2/02/2004	-	stead	a, MD	
Bal	permit. Departs Imports any inj		21. Signature of Funeral Service Licensee MOG/723		2. Name and Address 934 Sout		St, Hamps	Tuneral stead, M		074	
B			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyi	ing, such as ca	ardiac or respiratory	arrest,		Approxima Interval Be Onset and	etween
* - T	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Service tights are disease.  Hypothermia compute to (or as a consequent of the consequent o		ed by Acut	e Alcoho	l Intoxicat	ion		STIGGT WITE	
	uted d	Examiner	Sequentially list conditions, if any, leading to immediate auss. Enter thicknying Cause (Disease or injury that infitiated events	ice of):							
,092	ate be executed nysician and he burial-transit	cal Exa	resulting in death) Last Due to (or as a consequent	nce of):							
89	tifical 19 phy as th	edi									
.O. Box	The law requires that the death certificat ite has been signed by the attending phypage 2 should be detached for use as th	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 X Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnand Other (specify)	су			Date of deliver Month	very Day	Year
<b>Q</b>	w requires that the death been signed by the atte should be detached for	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause gr	iven in Part I.		ftobacco use co ]Yes 2□No			death? Unknown
Records,	sician: The law red certificate has bee irector, page 2 sho	Completed					24a. We	opsy formed?	were aut prior to c death?	opsy findings ompletion of 2 No	s available cause of
Vital		a)	25. Was case referred to medical			26. Place o	of Death (Check only				
>	> .0 0	ToB	examiner?  **XYes 2 \sum No	VOutpatier	nt 3 DOA	ther: 4 🗆 Nurs	sing Home 5 🗆 Re	sidence 6X10	ther (Spec	ify) AT S	SCENE
n of	ding Ph After th funeral			b. Time o	Wo	ury at		how injury occi			
Sio	Attending r death.	atic	2X Accident investigation 1/29/04	9:20	4	Yes 2 N	2023	exposed t			
Division	Direction	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home building, etc. (Specify)  Outside of home	e, farm, sti	reet, factory, office	)	City or T	(Street and Numown, State)			
	the Hospital hin 24 hours the Funeral I	dical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.								(s)
)	Withir Comp	W	29b. Signature and title of certifier	20.0		c.M.E		29d. Date sign		Day, Year) 2004	
	W 7		39 Name and address of person who completed cause of death (Item 2:	3a) (Type, Pen	Print) n Street	, Balt	imore, Mai	yland 2	1201		
12	St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signatur		1						
DH	IMH 17 Rev 1/		FEB 0 4 2004 Menus	K.	Goode						

		•	1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artmer rtificat	t of H	ealth a Death	and Me		giene Reg. No.	200			05
			1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	ath Day	Ye	ar	3. Time of D	eath
	Physicia /Medic				t E.	Gartne					January		2004		3:00p	М
· •	Examin		4a. Facility Name (If not institution, give						Location o			4c.	County of D			
			Montgomery Villag  5. Social Security Number 6. Se			last birthday)		Gait Tiyear	hersb		8. Date of Birt	h	Mont		ery ace (State or F	Foreign
П	Funeral Director			W 14 0	85	Yrs.	Months	Days	Hours	Min.	(Month, Da) Dec. 17	y, Year)		Count	yland	or orgin
			Usual Residence of Decedent	`								,				
	nylanc how		10a. State 10b. County		10c. City	y, Town or Lo	cation							10	od. Inside City 1 ☐ Yes 2	
	e Ma	cto	Maryland Montgo	mery	Gait	hersbu										. 140
	ith th	Directo	10e. Street and Number				10f. Zi						zen of Wha			
	s 23s	ral	19310 Club House	Road Apt.  12. Was Decedent		e 12	Was Deco		0886	nin? (Sne			ed St			
	Item Item	Funeral	11. Marital Status  1 □ Never Married 2 ★ Married	Armed Forces?		3. 13.	If Yes, spe	cify Cuba	n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		Black, V			
920	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWI		1 🗆 Yes	2 🛣 No	Specify:				Specify:	Wh	nite	
21215-0036	within 72 hours after death with the Maryland ene. then "natural" or items 23a or 28a-f show the Madical Exeminer mast be motified at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usu	al Occupa	ation during most	of working	ıa l	16b. Kii	nd of Busin	ess/Ind	ustry	
2	ithin 7.	npie	Elementary/Secondary (0-12)	College (1-4or	5+)											
S	lygier her th	ပိ	12 17. Father's Name (First, Middle, Last)			Owi	ner/0	pera		r'e Name	(First, Middle,		chine	Sh	ор	
and	be fi	Be							He1e			WAIGGI	Jumame,			
Ž	hould d Me	မှ	Millard J. Gartn 19a. Informant's Name/Relationship (7			19b. Maili	ng Addres	s (Street a			Route Numbe	er, City o	Town, Sta	te, Zip	Code) 208	96
Σ	od 2 s lith an 27 ts r treu		Harriett P. Gartn								Apt 10				be the second	00
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other then. "natural", or litems 23a or 28a-1 show any injury or other treumatic event, Ira Marical Examine mast be neithed at once.		20a. Method of Disposition		20b. P	lace of Dispo					ate		cation - Cit			
E	Page nent o nt: If rry or		1 ⊠ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		1					1/27	/2004	Lay	tonsv	i11e	Mary1	Land
alti	permit. Departir Importe any inju		21. Signature of uneral Service Licen	S00		2:	2. Name a	nd Addres	s of Facilit	v		74				
<u>m</u>	80 E 8 8		Hodel O	Ups	1	/ 28	5401	Ridge	e Roa	d, Da	P. A., amascus	, Ma	rylar	1d 2		
П			23a. Part1. Enter the disease, or comshock, or heart failure. List only	olications that caused one cause on each li	the death ne.	h. Do not en	ter the mo	de of dyin	g, such as	cardiac or	r respiratory ai	rrest,			Approximate Interval Betwee Onset and De	
) -	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. Aspirat			nia									
	/Medical Examiner		resulting an death)	Due to (or as	a conseq	uence of):										
		r e	Sequentially list conditions,	b. Hyporia Duato (or as	a consec	uanca of):										_
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to initingulate cause. Enter Underlying Cause (Disease or injury that initiated events	Hyperte	ntion	1										
Ć.	execting and items in and items in a training in a trainin	Exa	resulting in death) Last	Due to (or as												
8760,	ate be executed oblysician and the burial-transit	licai		d Atnai F	ibull	lation	<u>.</u>						,			
Ö	ing ph as th	Med	IF FEMALE:											-		
Box	death certific e attending pl id for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3	□Ectopic p		•			2	23d. Date o Month		ry Day Ye	ar .
	0 0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	t time or a	eath 5L	Other (s	респу)								
P.0	requires that the de teen signed by the a hould be detached f		Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	ınderlying	cause giv	en in Part I.		23a. Did t	obacco u	se contribu	ite to th	e cause of dea	ath?
gp.	Se Log	d by	Prostate Cancer.	Anemia							10,	Yes 2	∑No 3[	] Proba	ably 4 □Un	iknown
O O	> D 0	jete									24a. Was		24b. Wer	re autop	osy findings av	vailable
Vital Records,	e - e	Completed										ormed? 2 No	dea	th?	2 Duno	126 01
ital	ician: Th certificate rector, pag	O	25. Was case referred to medical						26. Place	of Death	(Check only o					
<b>&gt;</b>	8 0 0	To B	examiner? 1 Tes 2 KNo	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatie				rsing Hon	ne 5∐ Resi	dence (	6 □Other (	Specify	)	
n of	ting Phy.  After thi		27. Menner of Death 1 SNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Yəar)	28b. Time of Injury		28c, Injun Worl			8d. Describe	how injur	y occurred			
sio	Attending r death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		iumz - At h	omo farm et	M root facto		Yes 2□		28f. Location (	Street an	d Number (	or Bura	I Route Numb	
Division	t or Attendater deatl	Certification:	4 Homicide determined	28e. Place of In building, e	c. (Specif	y)	ieet, iacto	ry, onice		l l'	City or To	wn, State	)	J. 110.0.		-,
_	To the Hospitet or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	ledical C	(Check only 2 Medical Exer	ysician: To the best niner: On the basis of	of examina	owledge, deat	th occurred	at the tin	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manne place, and	er as st	ated. the cause(s)	
	To the within 24	Med	29b. Signature and title of certifier	and manner st	ated.		29	c. Licens	e number			29d. Dat	e signed (A	Иonth, l	Day, Year)	
	5 tik C		I nu Ga	NP WA				1.	1162	12	7	Inn	ary 2	2	2004	
	1541		30. Name and address of person who		death (Iten	n 23a) (Type.	. Print)	UU	1110	1 2	· V	Jaiil	ary 2	و د .	2004	
	10		Dr. Vinu Ganti,					Gern	nantov	wn. M	lary1an	d				
	Sta		31 Date filed (Month Day Year)	32. Regist	rar's Signa	ature				-						
	Regist	rar	JAN 28	CUU4 MA	ME	D. 1										

			Pleas				ndelible ink				_	
			For State	State o	r Marylar		partment of I e <i>rtificate of</i>			100	2006	16406
			Registrar  1. Decedent's Name (First, Middle,	Last)			erinicate or	Dealli	2. Date of Dea	th		3. Time of Death
	Physicia				GIANGI	RANDE		.J,	Month	28	2004	2:25 A M
	/Medic Examin		4a. Facility Name (If not institution,					or Location of Deat		_	County of Dea	
	LAUITIN	Ξ.	Frederick Memori	al Hospi	ta1		Frederi	ck		Fre	ederick	
	Funeral		5. Social Security Number		7. Age (In yrs.			If Under 24 Hrs	(Month, Day	Year)	9. Biri	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent	'A-7.\" 2	73	Yrs.			July 7,	1930	New	York
	land		10a. State 10b. County		10c. Ci	ty, Town or	Location					10d. Inside City Limits
	Many P-f sh	tor	Maryland Freder	ick	Fred	lerick						1 □ Yes 2 🕅 No
	or 28a	Director	10e. Street and Number				10f. Zip Code		1	l0g. Citiz	zen of What Co	ountry?
	23e	al	5597 Sedwick Co	urt			21702				ited St	
	tams	Funeral	11. Marital Status	Armed Fo	edent Ever in U rces?	J.S. 13	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1	4. Race - Ame Black, Whit	
20	rs afte	by F	1 ☐ Never Married XX Marne 3 ☐ Widowed 4 ☐ Divorced	d tylyyes If yes, Giv Year or D	2 □ No /e ates: 1951	<del>-</del> 53	1 ☐ Yes 2 No	Specify:			Specify: Wh	ite
2-003d	172 hours after death with the Maryland "natural", or Items 23e or 28e-f show colcal Exactly or main to incitited at		15. Decedent's	Education		16a. Dec	cedent's Usual Occu	pation		16b. Kin	nd of Business	/Industry
<u> </u>	hin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	I-4or 5+)	(Gi life	ve kind of work done  . DO NOT use retire	during most of wo	rking			
7	ad wit	Con	12			Own	er/Operate				aurant	
	be file d oth	Be	17. Father's Name (First, Middle, L.	ast)					me (First, Middle,	Maiden S	Sumame)	
<u>Z</u>	Men Men Marke Marke	2	Frank Giangrande			10) 11			<u>Valenti</u>	<b>A</b> 1:	<b>*</b> 0	
	12 sh h and 7 is m traum		19a. Informant's Name/Relationshi				iling Address (Street			-		
<b>5</b>	1 and Healt em 2		Leona Giangrande  20a. Method of Disposition	\ MITE	20b. i	DO9	7 Sedwick position (Name of rematory or other pla	Court/ F			vland eation - City or	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Infinited the Health and Mental Hygiens hetural, or Items 23e or 28e-f show important: Item 27 is marked other than "netural, or Items 23e or 28e-f show any injury or other traumatic event, Item Medical Exaction in an invalible invitified at page.		1 ☐ Burial AACremation :	3 □Removal from	State		rematory or other pla : Cremetory,		oraz 1.200/	Fred	lori de l	Maray Land
эапшо	nit. P vartme ortan injur injur		21. Signature of Funeral Service L		LL		22. Name and Addre					
۵	Deg man			Ch.	_0		1621 Oposs	sumtown P	ike/Fred	eric	k Marv	land 21702
	Mr. Sign	1	23a. Parv. Enter the diff als., or of shock, or heart failure. List o	o prications that c	auseathe dea						TO THE TOTAL	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	D	enal	fa.	11110					Onset and Death
	/Medical		resulting in death)	_ a	or as a consec	quence of):	, 1014					041
	Examiner		Sequentially list conditions.	b. H	400	tens	100					24 hrs
	p ti	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intend expenses)	Due to (	ur 4s 5 consec	quence of):	+	_	1 -			2-31-0
	be executed ician and burial-transil	Examin	that initiated events resulting in death) Last	c. Due to	or a a consec	guence of):	ial	nfarc	Tion		_	1-300gs
9	be e sician buria	al E				. ,						
20	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	edlo		0								
OX	anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		. O E - t i			2:	3d. Date of del	ivery
מ	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		B□Ectopic pregnanc □ Other (specify) _	у			Month	Day Year
л Э	The law requires that the tite has been signed by thoage 2 should be detached.	Physiclan/Medl	9 Unknown	1								
Ś	res th signed be d	by	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the	underlying cause gr	ven in Part I.		bacco us es 2□		o the cause of death?
ecords,	requi	Completed	211	opar ny	1 (	1	<i>c</i> 1				-massic_	
န္ ဂ	elaw hasb je 2 si	mple	Huti phosp	ndlipid	antib	ody	Synovo	ne	24a. Was a autops	sy	24b. Were au prior to death?	itopsy findings available completion of cause of
	n: Th icate r. pag		<u>'</u>						1 ☐ Yes ∡	2₫No		2 🗆 No
VIII	siciar certif recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital:	epatient 2	ER/Outpati	Ct	n A m	ath (Check only on	111	T011-1- (C	-4.)
ō	Phy ar this aral d	$\vdash$	27. Magner of Death	28a. Date	of Injury	28b. Time	of 28c, Iniu	rv at	lome 5 Reside			спу)
0	nding ath. r: Afte e fune	atlor	1/≅Natural 5 ☐ Pending 2 ☐ Accident investiga		th, Day Year)	Injury		rk? ]Yes 2 □No				
DIVISION	Atte	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place	of Injury - At h		street, factory, office		28f. Location (St City or Town		Number or Ru	ıral Route Number,
5	tal or rs afte al Dii	Cer							,			
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	edical	(Check only 2 Medical E	Physician: To the xaminer: On the b	best of my knoasis of examina	owledge, de ation and/or	ath occurred at the ti	me, date and place	a, and due to the carred at the time, d	ause(s) a ate and i	and manner as place, and due	stated. to the cause(s)
	the hin 2, the l	Med	one) 29b. Signature and fifte of certifier	and manr	ner stated.		29c. Licens		. ,		signed (Monti	
	Z × S		200. digitature di partire di continei	TC 11.	14.		A A			1/2	9/84	-, - my) / ww//
	7)		30. Name and address of person w	to completed caus	e of death (le	m 23a) /Tun	e. Print)	55/04		1/2	-1/0/	
,	0		Ga J 6	FAIR		0 Z	So Mai	n mr	AIVS	mo	217	7/
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign		frank 1					
	Registr	ar	181	a a 2004 h	Pilatus	100	A VIII					

			For State	State of Ma	ryland / Depa	artment of Hea	alth and M	ental Hygier	ne <sub>2001</sub>	01.1.07
			Registrar		Cei	rtificate of De	eatn	Reg. I	No.C U U S	UN HU /
	Physicia	an	Decedent's Name (First, Middle, Las.		_			<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Medic		NAPOLEON	GRA	Y			JANUARY	16, 200	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Lo			4c. County of Death	
			CLINTON NURSING		(In use look hirthday)		NTON f Under 24 Hrs.	8. Date of Birth	PRINCE G	
	Funeral Director		5/8-66-6682	M 2□F	(In yrs. last birthday) 54 Yrs.		Hours Min.	June 26	1949	place (State or Foreign intry) Wash., DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryl f sho	ō	D.C		VJ =	shington				1X∐Yes 2 □ No
	15e 1	Director	10e. Street and Number		***	10f. Zip Code		10g.	Citizen of What Co	untry?
	Sa or		713 Quincy	S+ NW.		2	20011		United S	tates
	death ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No-	14. Race - Amer	ican Indian,
50	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. A dether than "natural; or items 23s or 28e-f show do other than "natural; or items 23s or 28e-f show svent, the Madical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Micropole	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		nicari, etc.)	Specify: B	lack
21215-0036	2 hou	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupation	on ing most of working	16b	. Kind of Business/I	ndustry
22	hin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired)	ing most of working	,g		
N	giene giene	PO.	10th			Laborer			Labo	r
힏	be filed ital Hygi id other svent, ii	Be (	17. Father's Name (First, Middle, Last)			18	B. Mother's Name	(First, Middle, Maid	len Sumame)	
<u> </u>	should be and Menta a marked umatic sy	은	Unkn	own			I	Daisy Gra	У	
Maryland	A B E E		19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street and				ip Code)
	s 1 and 2 should of Health and Men item 27 Is marke other treumetic			x-wife		uincy St.,		Wash., Do		
ore Ore	0 O		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, crea	matory or other place)		ate 20c	Location - City or	own, State
Ĕ	Pages nent of ent: If it ury or o		'4 □ Donation 5 □ Other (Specify			tion Cem.	1-26-	-04	Clinton,	Md.
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Lic in	PRANT	U 1111	2. Name and Address of 425 Marylar		apitol Mo: NE Wash	• •	nc. 002
			23a. Part1. Enter the disease, or composition of the shock, or heart failure. List only	plications that caused to	de death. Do not en	ter the mode of dying,	such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Enysician		Immediate Cause (Final		nare processor energy as	PERTATENAL	7 C57311 CN	4TC		Onset and Death
	/Medical		disease or condition resulting in death)	-	consequence of):	DEFICIENCY	SYNDROP	1E		
	Examiner			AMYOTR	OPHIC LATE	ERAL SCLERO	OSIS			
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i	Due to (or as a	consequence of):					
	te be executed ysician and e burial-transit	Examiner	that initiated events	C						
o	an ar rial-tı		resulting in death) Last	Due to (or as a	consequence of):					
760,	te be ysicii ne bu	ca		d						
68	leath certificate attending phy I for use as the	Med	LE CELLUI E							
Вох	h cer endir r use	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		☐Ectopic pregnancy			23d. Date of deli	very Day Year
m	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4☐ Pregnant at t		Other (specify)			Month	Day Feat
Р. О.	at the de by the a	hy	9 🗆 Unknown							
	igned I	by F	Part II. Other significant conditions of	-	t not resulting in the u	anderlying cause given	in Part I.			the cause of death?
ğ	w require been si should t	ed	POOR ORAL INTA	KE				1 Tes	2 No 3 Pro	bably 4 Unknown
of Vital Records,	law re	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
œ	The la	Ę						performed 1 ☐ Yes 2 🛱	? death? No 1 ☐ Yes	2 □ No
<u>ia</u>	icien: Th certificate rector, pag	Be	25. Was case referred to medical			2	6. Place of Death	(Check only one)		
>	ysici is ce direc	To E	examiner? 1 ☐ Yes 2 【▼No	Hospital: 1 ☐ Inpatier	nt 2□EP/Outpatie	nt 3 DOA Other:	4 Nursing Hor	ne 5 🗆 Residence	6 □Other (Spec	ify)
0	ding Phys th. : After this of funeral dir		27. Manufer of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Injury a Work?	t	28d. Describe how in	njury occurred	
<u>.</u>	Attendir death. ctor: Af y the ful	atic	2 Accident investigation				s 2 □No			
Division	Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certifica tely filled in by the funeral director, is	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, st . (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S		ral Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		ysician: To the best o niner: On the basis of and manner stat	examination and/or in					
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License r	number		Date signed (Month	
	F ₹ F 8		1 Brum	/ I DN		51:	520	l	-20-0	4
•	411		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)				
	086		BAHRAM PISHDA			nern Ave.,	S.E. St	te. 310	Wash., D	C 20032
	(4)	ate	31. Date filed (Month, Day, Year)		r's Signature	,				
	Regist		JAN 2 7 2004	Vac. A	Sand ,					

		•	FOr	oartment of Health and M ertificate of Death		ene 2001	04408
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mary Virginia Griffin-Hunter		1	21 04	2:02 A.M.
7	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	_
			Prince George's Hospital	Cheverly  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	hplace (State or Foreign
Ę	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 226−34−6893 1	Months Days Hours Min.	3/22/19	'ee <i>r)</i>   Co	untry) rginia
The	Director	-	Usual Residence of Decedent		3/22/17		
	yland how		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	a-f-e	cto	MD Prince George's Landove	r			1 ☐ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number 1415 Belle Haven Drive	10f. Zip Code 20785	-	g. Citizen of What Co 'SA	untry?
	ath w	Funeral Director				14. Race - Ame	rican Indian
	er de Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1. □ Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Black, White	
36	irs aft	by F	3 ⊠ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specity: B1a	ck
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then 'natural', or tlems 23s or 28s-( ehow ent, the Macilcal Examiner must be instifted at	ted		cedent's Usual Occupation ive kind of work done during most of work		6b. Kind of Business/	Industry
215	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	a. DO NOT use retired)		Private	
21	filed wi Hygien other th	Completed		mestic	e (First, Middle, Ma		
Maryland 2121	0 = 5	Be	17. Father's Name (First, Middle, Last) Edward Griffin	Emma Di		ilderi Sumame)	
2	should be tand Mental I s marked o	2		ailing Address (Street and Number or Run		City or Town, State, 2	Zip Code)
Z	d 2 s th an 27 Is r traur			•		, MD 20785	
	Heal Heal tem		20a Method of Disposition 20b. Place of Dis			c. Location - City or	
JOE L	Pages ent of t: If I		11 Rurial 2 MiCremation 31 Hemoval from State	Le Crematory 2-1-	04 R	iverdale,	MD
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic e one.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $J$ . $E$			
ä	Depa Impo any is		K. D. Harshall	7474 Landover Rd.	Landover	, MD 20785	
'n			23a. Part 1. Enter the disease for complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	rt,	Approximate Interval Between Onset and Death
40	Physician		Immediate Cause (Final disease or condition	Syndroma			M D J R S
in the	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
25	Examine	_	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence of):	( Co			DAYS
	ed isit	nine	if any, leading to immediate cause. Ever indepty. Cause (Disease or injury	us Vicerations/	Ton Feet	1300	Mortu
	xecul and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	0. 0.000 (000)	7.7.201		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	calE	d				
89	uficati g phy as the	edi					4 <del>-1</del>
Box 6	h cer endin r use	N/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of del	livery Day Year
B	ed for	sicla	In the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death	5 Other (specify)		Mortin	Day Teal
P.O.	es that the death certific igned by the attending p be detached for use as	Physiclan/Med	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	a undarbing causa swan in Part I	23e Did toha	acco use contribute to	the cause of death?
S,	res the	by	Part II. Other significant conditions continuous to death out not resolving in the	Builderlying cause given in Francis	1 ☐ Yes	1	robably 4 🗀 Unknown
000	v require been sig	etec	2		24a. Was an	24h Wara au	utopsy findings available
Records,	The law cate has page 2 :	Completed	A I		autopsy perform	ed? prior to death?	completion of cause of
ā		e Co	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 h (Check only one		2 □ No
>		ToB	examiner?  1 Yes 2 No Hospital: 1 Depatient 2 ER/Outpa	Others		nce 6 Other (Spe	icity)
10			27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at Work?	28d. Describe how	v injury occurred	
Sior	Attending F r death. ector: After by the funer	atic	2 Accident investigation	M 1 Yes 2 No			
Division of Vital	or Attendate death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or Attentivitin 24 hours after deatl To the Funeral Director:	Ce	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and store	and due to the co-	ica/c) and masses as	stated
	Hospital 24 hours a Funeral I stely filled	edical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)				
	To the l within 2 To the I	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	•
	FSFO		> 1/ 1/ 1 Steer	000 52865		January	21,2004
0	1(4)		30. Name and address of person who completed it use of (eath (Item 23a) (Ty		-		
1	(3)		K. Michael Figaro 1001 Hospital	Dr. Cheverly, MD	20785		
		ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature  JAN 2 8 2004				
	Regist	rar	JAN 2 8 2004	MO J			

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland		artment of F rtificate of			giene , Reg. No.	2004	04409
1			Decedent's Name (First, Middle, Last)				2. Date of De Month	aath Day	Year	3. Time of Death
	Physici /Medic		Darryl M. Gross				January	7 18	2004	4:00 P M
}	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of De	eath	4c. C	County of Death	
			Holy Cross Hospital		S	Silver S	pring		Montg	omery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la		If Under 1 Year Months Days		in. (Month, Da	av. Year)	9. Birth	place (State or Foreign
	Director		415–76–7242 <sup>1</sup> <del>X</del> <sup>M 2□ F</sup> 56	Yrs.			Oct. 9,	1947	7 Te	nnessee
	D >		Usuel Residence of Decedent         10a. State         10b. County         10c. City,	Town or Lo	position					10d. Inside City Limits
	anyla shov	٦		TOWN OF EC						1∭Yes 2□No
	18a-1	ecto	Maryland Prince George's		Lando 10f. Zip Code	ver		10a Citia	en of What Cou	
	with t	ā	6603 Asset Drive		Tor. Zip Code	20705				_
	s 23	ra		12	Was Doordoot of I	20785	(Specify Ves or No		Jnited :	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinat must be retilized at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 M No If Yes, Give Year or Dates:		if Yes, specify Cub		(Specify Yes or No erto Rican, etc.)		Black, White Specify: Am	r <b>i</b> can
21215-0036	2 hou	ed	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation		16b. Kind	d of Business/Ir	ndustry
15	n 77	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of a	working			
212	with jene	E	Elementary/Secondary (0-12) College (1-401 5+)		School	Teacher			Gover	nment
Ö	filed Hyg othe	BeC	17. Father's Name (First, Middle, Last)			18. Mother's f	Name (First, Middle	, Maiden S	Sumame)	
a	lid be fenta rked lic e	To B	Theodore Gross				Barb	ara C	Carson	
Maryland	shou and N umal		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City or	Town, State, Zi	p Code)
	alth a 27 ls		Marilyn E. Gross - Wife	66	03 Asset	Drive,	Landover	, MD	20785	
ē,	f Her Item othe		Co. Monto of Co.	ce of Dispo	sition (Neme of natory or other pla	ice)	Date	20c. Loca	ation - City or T	own, State
Ĕ	Page nent c nt: If		1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State  *4 ☐ Donetion 5 ☐ Other (Specify)	Lee's	Cremato	ry 1/3	30/2004	C	Clinton	, MD
Baltimore,	permit. Pages 1 and 2 a Department of Health at Importent: If Item 27 Is any injury or other trac		21. Signature of Funeral Service Licensee	22	2. Name and Addre		Stewart	Funer	al Home	2
m	permil Depar Impor any ir		bohm T. Slewer !!!		4001 B	enning	Rd., N.E.	Wash	1., DC	20019
			23a. Part   Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line.	Do not ent	er the mode of dyi	ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Ischemic							Onset and Death  1 Year
1	/Medical		resulting in death)  Due to (or as a consequence)		Omyopach	y				1 Teat
	Examiner		Sequentially list and disings							
-	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ence of):						
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events c.							
ó	e exe ian a urial-t	ŭ	resulting in death) Last Due to (or as a consequence	ence of):						
8760,	icate be executed physician and s the burial-transit	dical	d							
9		au ·	IF FEMALE:							
.O. Box	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	death 3	Ectopic pregnanc Other (specify)	y		23	3d. Date of delive Month	ery Day Year
<u>α</u>	that led by deta	된	Part II. Other significant conditions contributing to death but not resul	ting in the u	nderlying cause gr	ven in Part I.	23e. Did t	tobacco use	e contribute to	the cause of death?
Records,	uires sign	d by	Staphylococcal sepsis and ab	scess	,		10	Yes 2 🛚	No 3□Pro	bably 4 Unknown
00	w require been si should b	Completed	end stage renal disease, typ	e two	diabete	S	24a. Was	an	24b. Were auto	opsy findings available
Re	The law	F						ormed?	death?	opsy findings available empletion of cause of
a			mellitus 25. Was case referred to medical			OF Place of I	1 ☐ Yes Death (Check only o	1	1 🗆 Yes	2 LI No
of Vital	Physician: this certific ral director,	o Be	examiner?	B/Outpaties	t 3□ DOA Ot	hon	g Home 5 ☐ Resi		Other (Speci	fr)
of	g Physier this	1:10		28b. Time o			28d. Describe			'97
Division	Attending r death. ector: After by the fune	皇	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		rk? ]Yes 2∐No				
/isi	Attendir death.	fica	3 Suicide 6 Could not be 28e. Place of Injury - At hor	ne, farm, st	reet, factory, office				Number or Rur	al Route Number,
Ö	a afte	Certification;	4 Homicide determined building, etc. (Specify)				Chy dr 10	wn, State)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my know 2 Medicel Examiner: On the basis of examination and manner stated.							
	To th within To th comp	Ž	29b. Signature and title of certifier?	11	29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
•	~		expen a lank	Mr.	45	D47188		Jan	uary 19	, 2004
0	(/_)		30. Name and address of person who completed cause of death (Item	23а) (Туре,	Print)					
1	(0)		Jeffrey A. Perlmutter, M	I.D.	6240 Mon	trose Ro	d., Rockv	ille,	MD 20	852
	Sta Regist		31. Date Hilled (Month, Day, Year) JAN 3 0 2004 See See See Segment	Jre .						
DI	MH 17 Rev 1/2		person st	A TOP A						

DHMH 17 Rev 1/2001

			1- For State	State of Maryla	nd / Depa	artment c	of Health a	nd Mental H		•	01110
			Registrar AMEND #18 P		cchDCe	rtificate	of Death		Reg. N	.ZUU!	1 04410
	Physic	ian	Decedent's Name (First, Middle, Last, GERALD JOSEPI					2. Date of Month	D	ay Year	3. Time of Death
>	/Medi		4a. Fecility Name (If not institution, give			4b City Toy	wn, or Location of	JANUA		8, 2004 c. County of Dea	6:10 P M
	Examir	ner	MILLENNIUM HEALTH		TFR		ASHINGTO			RINCE GI	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs	s. last birthday)	If Under 1 Y					rthptace (State or Foreign ountry)
	Director		210-22-3373	DM 2□F 74	Yrs.	Montris	ays Hours	MAY 6	, 19	29 PENI	NSYLVANIA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary I-f eh	to	MARYLAND PRINCE GI	EORGE'S		ACCOK	EEK				1 ☐ Yes 2/OXNo
	th the	Director	10e. Street and Number			10f. Zip Co	de		10g. C	itizen of What C	ountry?
	ath wi	ral	18207 LIVINGSTON				20607			NITED S	TATES
	ltams Itams	Funeral	11. Maritat Status  1 Never Married 2 Married	12. Was Decedent Ever in larmed Forces? 1 XYes 2 No 19	U.S. 13. \	Was Decedent f Yes, specify	of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Reca - Am Black, Whi	
920	urs af	by	3 Widowed 4 Divorced	WV Cit	49	I□Yes 🍇	No Specify:			Specify:	WHITE
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. d other then "natural", or Itams 23a or 28a-f show event, the Madical Exprisite must be mailined at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	fent's Usual O	ccupation one during most of	of working	16b. i	Kind of Business	
121	vithin ne. hen	mple	Etementary/Secondary (0-12)	Cottege (1-4or 5+)	life. L	DO NOT use re	etired)			C COLLE	0.7.47.17
2	filed with Hygiene ther the		1 1 17. Father's Name (First, Middle, Last)		ELECI	RUNIC	ENGINEER	s Name (First, Midd		S. GOVE	RNMENT
lan	should be filed nd Mental Hygi marked other imatic event, I	To Be	EDWARD HILWIG					- WILSON			
Maryland	s 1 and 2 should if Health and Men Item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (St		or Rural Route Nun			Zip Code)
	1 and 2 Health em 27 I		FLORENCE A. HILWIG					EK, MARYI	AND	20607	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R	emoval from State	Place of Dispo- cemetery, cren	natory or other	·place) JA	NUARY	20c, L	ocation - City or	Town, State
Itim	permit. Page Department of mportant: If any injury or once.		* 4 □ Donation 5 □ Other (Specify)  MG Sign stury of Figure 1 Servicer Signstone	HU	NTT CRE			1, 2004		DORF, M	ARYLAND
Ba	permit. Departm Importa eny inju		Market	M0005				HUNTT FUN LDORF, MA			24
	E 550		23a. Part1 Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea						ND 2060	Approximate
	Physician		Immediate Cause (Final disease or condition	PARCI	11000	A	OF TIL	ELUN	6		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		///	MUN			MONITO
-	LAdillilei	10	Sequentiatly list conditions, if any, leading to immediate	Due to (or as a conse							
	ned	Examiner	Cause (Disease or injury	Due to (or as a conse	quenca or):						
Ć,	execu in and ial-tra	Ехаг	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):						
68760,	death certificate be executed e attending physician and of for use as the burial-transit	cal		l							
89 )	ing ph	Med	IF FEMALE:								
Box	leath certificat attending phy I for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet	at death 3 🗌	Ectopic pregna				23d. Date of del	ivery Day Year
P.O.	that the de ed by the a detached t	yslc	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5□	Other (specify	<u>'</u> )			Wildia	Day . oai
s, P.	requires that the een signed by th hould be detache	ьу Рһ	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause	given in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
rds	w requires been sign should be		(HKONIC DESTI	DETIVE	LUNG	Dis	EASE	1)3	Yes 2	□No 3□Pr	obabiy 4 🗆 Unknown
Record	aw s b	ompleted	DIABETES M	ELLITUS		•		24a. Wa		24b. Were au	itopsy findings available
E E	The ate h page	Com						per 1 Yes	opsy formed? 2021 No	death?	completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	a a sitat.			The second second	Death (Check only			
of	Phys this ral dir	. To	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient	3 DOA	Other: 4 Nursi	ng Home 5 Re			cify)
on	Attending Phir death.	ıtlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	,	Mork? 1 ☐ Yes 2 ☐ No	28d. Describe	injini won e	ry occurred	
Division of Vital	after deat Director: In by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, offi	ice				ıral Route Number,
Ö	itel or A	Cer							own, State	<i>.</i>	
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check thiny 2 Medical Examin	ician: To the best of my knows: On the basis of examinating	owledge, death ation and/or inv	occurred at the	e time, date and p ny opinion, death	place, and due to the	e cause(s)	and manner as	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.			ense number			te signed (Montl	
)	⊢s⊢ŏ			$4\mathcal{N}$		0	1291	4	/	1001	1
Ę	•	1	30. Name and address of person who	mpteted cause of the (tter	m 23a) (Type, P	Print)	100100	)	-11	2766	)
D	B1591			MD, 12070 0		CENTRE	£, #207,	WALDORF,	MARY	LAND 20	602
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 3 2	32. Registrar's Signal	ature,	oest!					

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** RAYMOND CLYDE HEAD January 12:10 23,2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Memorial Hosp. Frederick Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept. 28, 1932 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 219-30-235 Days Hours Md. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f ehow 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at Burkittsville Md. Frederick 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Main West 109 21718 U. S. A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No within 72 hours after 1 Never Married 2 Married 0 1 ☐ Yes 2 No Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Printing Company College (1-4or 5+) Computer 12+4 programer 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Sumame) Head, Sr. Raymond 6 (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Irmtraud West Main Burkitsville Md. 21718 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cremating Jan 26, 2004 Smithsburg. Md. Name and Add and Facility George L. Rollins Frenewal Hom 110 West South St. Frederick 21. Signature of Funeral Service Ligens yang L. Maryland 23a. Part 1. Enter the disease, or shock, or beart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** STROKE Minutes resulting in death) /Medical Due to (or as a consequence of): **Examiner** Asmation Preumoma Sequentially latic and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a consequence of) Examiner certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Pe Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) 13091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick My House Are STREAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2004 Registrar

			For	State of Maryland	d / Depa	rtment of H	ealth and I	Mental Hyg	iene	
		•	For State Registrar			tificate of E		R	eg. No. Z U U	4 044 2
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Ye	3. Time of Death
	/Medic	al	MARY EI  4a. Facility Name (If not institution, give s	LIZABETH	Н	4b. City, Town, or	Location of Deat	JANUAR	Y 25 20 4c. County of I	04 2:08p M
	Examin	er	Frederick Memoria			•	erick			erick
×	Funeral		Social Security Number     6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Yeer) 9.	Birthplace (State or Foreign Country)
	Director		226-01-8712 Usual Residence of Decedent	87	Yrs.			Nov. 23	, 1916	Virginia
/land	WOW		10a. State 10b. County	1 .	, Town or Lo					10d. Inside City Limits
э Мал	a-f sh liffed	ctor	Maryland Frederi	ick	Brui	ıswick				1 No 2 No
death with the Maryland	lai Hygiene. d other than "natural", or items 23a or 28a-1 show event, i'ra Medical Exarcinar must be notified at	Funeral Director	10e. Street and Number	T		10f. Zip Code 21716		1	Og. Citizen of Wha United	
eath v	ns 23e	erai	1201 Maple Terrace	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-	14. Race -	American Indian,
10	or for	F	1 Never Married 2 Married	Armed Forces? 1		Yes, specify Cubar  ☐ Yes 2X No	n, Mexican, Puer Specify:	to Hican, etc.)	Specify:	White, etc. White
DOG Nours	al Hygiene. Jother than "natural", or Item event, the Medical Exection	d by	3 ☐ Widowed 4 M Divorced	Year or Dates:					16b. Kind of Busin	
<b>15-</b> 0	nati	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Give	ent's Usual Occupa kind of work done d OO NOT use retired,	lurina most of wo	rking	16b. Kind of Busin	ess/industry
z with	r than	omo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Offic	e Manage	r		Plastic (	Company
	al Hyg	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle, i	Maiden Sumame)	
Taryland 2 should be 1	6 5 0	2	Harry Jones	Defeat)	10h Mailie	g Address (Street a	Agnes		r City or Town Sta	ute. Zin Code)
Maryland 21215-UU36 d 2 should be filed within 72 hours aft	th and M 17 is mari traumati		19a. Informant's Name/Relationship (Ty, Ronald Hill / Son	pe, Print)	9 West	orndorf:	f Dr. Br	unswick,	MD 21716	)
4, 4	H P		20a. Method of Disposition	20b. P	tace of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - Cit	y or Town, State
Page P	nent ol		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		rk Heig	ghts Cem.	1-3	0-04	Brunswic	-
Baltimore,	Department of H Important: If ite any injury or ott		21. Signature of Funeral Service License	30	22	. Name and Addres	s of Facility St	auffer F	uneral Ho ck. MD 21	ome 1716
<b>.</b> .	05 8 9	$V_{\perp}$	Hung A.	inations that cause the						Approximate
		_	234. Part1. Enter the disease, or collection whock, or hand failure. List only the late Cause (Final	use on each ne.	1 (4) (	A	9, 00011 20 021 014	o o,,		Interval Between Onset and Death
The state of	ysician Medical		dis this or condition resulting in death)	Due to (or as a consequ		7				2 WKS
E	caminer		Conventially list conditions	o						
D.	sit .	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events	Due to (or as a consequence	uence of):					
<b>760,</b> e be executed	and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	uence of):					
760, ebeex	rsicien e buria	caiE		d						
	ed by the attending physicien and detached for use as the burial-transit		IF FEMALE:						<del></del> )	
Box Jeath cert	ttendir or use	lan/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ideath 3□	Ectopic pregnancy			23d. Date of Month	
. E	the a	ysic	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	eath 5L	Other (specify)				
Division of Vital Records, P.O. I or Attending Physician: The law requires that the d	ed by detac	by Physician/Med	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
rds	been signed should be det							1□Y	es 2 <b>A</b> No 31	Probably 4 Unknown
eco law re	has been je 2 shoul	piet						24a. Was a	sv pric	re autopsy findings available ir to completion of cause of
= E	page	Completed						1 ☐ Yes	med? dea 200 No 1□	m? Yes 2□ No
Vita ician:	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	FB/0-1	other actions	or.	ath (Check only or	ne) lence 6 □Other	(Cassiba)
O Phys	r this aral di	T: To	1 ☐ Yes 2 No 27. Manper of Death	28a. Date of Injury	28b. Time o	28c. Injury	y at		ow injury occurred	
ion	ath. r: Afte	Certification:	1 Alatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 🗆	Yes 2 □ No			
ivis r Atte	after de Directo I in by th	rific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Division of Vital Records, P.O. Box 68	within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier Certifying Phy	sicien: To the best of my kno	wiedge deat	occurred at the tin	ne, date and place	e, and due to the	ause(s) and mann	er as steted.
Hos	within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medical Exami	iner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	pinion, death occ	surred at the time, of	date and place, and	due to the cause(s)
Toth	within To th comp	Me	29b. Signature and title of certifier	10	ИА	29c. License			29d. Date signed (	
}			· (.).	Marin	U		016675		JIM 2	7, 2004
12			30. Name and address of person who co	ompleted cause of death (Iter	п 23а) (Туре,	Print) RR (1)	MCK	MD 2	21716	
1	C+	ate	31. Date filed (Month, Day, Year)	32. Registras Signa	ature	BRUNSL	)		1110	
	Regist		JAN 2 1	8 2004 > Manage	J. M.	mede				

S. Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 214-7021  Social Security Number 14-7021  Social Security N	of Deeth  ederick  9. Birthplace (State or Foreig Country)  Maryland  10d. Inside City Limits XXYes 2 No  What Country?  States e - American Indian, k, White, etc.  White  usiness/Industry  on Star News  ie)
Second   S	of Deeth  ederick  9. Birthplace (State or Foreig Country)  Maryland  10d. Inside City Limits XXYes 2 No  What Country?  States e - American Indian, k, White, etc.  White  usiness/Industry  on Star News  ie)
S. Social Security Number 214-7021 8. Sex 1 Industry 1 Industry 1 Industry 2 Industry 1 Industry 2 Industry 3	9. Birthplace (State or Foreig County)  Maryland  10d. Inside City Limits  Xayes 2 No  What Country?  States e - American Indian, sk, White, etc.  White usiness/Industry  on Star News
10a. State   10b. County   10c. City, Town or Location   10d. City, Town or Location   10d. City   1	Mhat Country?  States e - American Indian, ck, White, etc.   White usiness/Industry  on Star News
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumamus Joseph Wentz  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, M. Frances Stuart/ Daughter  20a. Method of Disposition  1 Burial XM Cremation 3 Removal from State  1 Burial XM Cremation 3 Removal from State  1 Comments, crematory or other place)  2 Name and Address of Facility Stauffer Funeral  2 Name and Address of Facility Stauffer Funeral  1 Comments of Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral  1 Comments of Facility Stauffer Funeral	usiness/Industry on Star News ne)
Solution   1980   198	ιθ)
20a. Method of Disposition  20a. Method of Disposition  1 Burial XX Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21 Sometimes Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral  1621 Opossumtown Pike/Frederick, N	State, Zip Code)
Acons C. Cavera 1621 Opossumtown Pike/Frederick, N	city or Town, State erick Mary Land
Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  APENSCARC INOMA OF THE PANCILAS  Due to (or as a consequence of):	Maryland 21702 Approximate Interval Between Opset and Death
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d. Due to (or as a consequence of):	
e the second se	e of delivery hth Day Year
	ibute to the cause of death?  3 Probably 4 Unknown
24a. Was an autopsy performed?	Vere autopsy findings available rior to completion of cause of eath? □ Yes 2□ No
27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  Work?  28d. Describe how injury occurre	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and man	
and manner stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed  1/29	(Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BRIAN M. D'CONNOR ND 501 W. SEVENTH 8T. FREASCICK  State  31. Date filed (Month, Day, Year)  32. Regis fat's Signature	

			riease i	State of Maryland / Dep		-	•	
			1 - For State Ragistrar		ertificate of Death	Reg.		04414
	D		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medi			andley		January :	22, 2004	11:00 A M
4	Examir	ier	4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Death	1	4c. County of Deeth	
	F		4465 Maple Dam Ro		Cambridge  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Dorches 9. Birthol	
н	Funeral Director			M 200 F 97 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Dey, Yo April 25,	1906 Mar	ace (Stete or Foreign try) Vland
	pur &		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			Od. Inside City Limits
	with the Maryland e or 28a-f ehow be notified at	ō	MD Dorches		Cambridge			1 □ Yes 2 ¼ No
0	1 the 1	rect	10e. Street and Number	ocei	10f. Zip Code	10g.	. Citizen of What Coun	try?
- <del>-</del> \	23e o	Funeral Director	4465 Maple Dam	Road	21613		U.S.A.	
	r deeth	iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: wh	ite
21215-0036	be filed within 72 hours after deeth with the Marylar hal Hygiene. ed other then "naturel", or flems 23e or 28e-f ehow event, the Medical Examinat must be notified at	ted t	15. Decedent's Edu	cation 16a. Dec	edent's Usual Occupation	160	b. Kind of Business/Ind	lustry
215	thin 7 e. en "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Giv life.	e kind of work done during most of wor DO NOT use retired)	king		
	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ita M.		unknown		homemaker	- (T) - 14: - 14 - 14	own hom	е
Maryland	ould be fi Mental H arked of atic ever	Be	17. Father's Name (First, Middle, Last)  Charles E. Wille	27		ne (First, Middle, Mai	den Sumame)	
Z	2 should and Men ie marke sumatic	ဥ	19a. Informant's Name/Relationship (Ty)	4	LUIE  ling Address (Street and Number or Ru	l Elzey  ra/ Route Number, C	ity or Town, State, Zip	Code)
			Carroll C. Handle		Maple Dam Road,			
Baltimore,	ges t and t of Health If item 27 or other tr		20a. Method of Disposition	20b. Place of Disp			c. Location - City or Tox	wn, State
Ë	nit. Pages artment of l ortant: If it injury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)		r Memorial Park 1	/26/04 c	ambridge, 1	MD)
3all	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service License			Thomas Fun	eral Home 1	P.A.
	40349	- 15		cations that caused the death. Do not en	700 Locust St., Co			Approximate
	Dharistan		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	ner the mode of dying, such as cardial	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):			or or	ditys
0	Examiner		Sequentially list conditions,					
	pe jis	iner	d any, leading to immediate cause. Enter Underlying	Due to (or as a consuguence of):				
	te be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	.  Due to (or as a consequence of):				
760,	e be e /sicien e buria	calE					176	
68		edic						
Вох	eath certificat attending phy for use as the	M/us	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of deliver	
	at the death certifica by the attending ph tached for use as th	Physician/Medi	in the past 12 months?		Other (specify)		Month	Day Year
P.0	that the		9 ☐ Unknowh  Part II. Other significant conditions con	tobuting to death but not resulting in the	underlying cause given in Part I	23e Did tobac	co use contribute to the	e cause of death?
Records,	es pe	d by	Hypertension		and only and cause given and and i.	1 ☐ Yes	1	abiy 4 ∐Unknown
00	> 40	Completed	11110			24a. Was an	24b. Were auton	sy findings available
Re	e h e h age	omp		·		autopsy performed	prior to com death?	pletion of cause of
Vital	certificat ector, pa	Be C	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	NO TO THE TES	
of V	N S ID	To 1	1 □ Yes 2 No	ospital: 1   Inpatient 2   ER/Outpatie		ome 5 Pesidenc	e 6 □Other (Specify,	)
uc		ion:	27. Manner of Seath  1 Pending	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how i	injury occurred	
Division	or Attending after death. Director: After in by the fune	ficat	Accident investigation    Accident investigation	28e. Place of Injury - At home, farm, s		28f. Location (Stree	t and Number or Rural	Route Number,
Ö	el or A s after at Dire	Certification:	4  Homicide	building, etc. (Specify)	,,	City or Town, S	itate)	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier Cartifying Physical Exemple	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i	ith occurred at the time, date and place	, and due to the caus	e(s) and manner as sta	ated.
	To the h within 24 To the F complete	Medical	one)	and manner stated.				
)	To to	-	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	/ey, rear)
			30. Name and ardress of person who co	mpleted cause of death (Item 23a) (Type	Print) (1) 1773		100101	
			Eugone A	Jewmire D.C.	503 Bur	nSt C	ambrida	MD21612
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	62			
*	Registr	ar	JAN A J ZU	Salara St. B.				

		1 - State Registrar  1. Decedent's Name (First, Middle	I acti		-	artment of H	Death	2. Date of Dear	eg. No. 2	104	04415
Physici: /Medic		EGBERT HOLMES		JR.				Month  JANUARY	Day 28	Yeer 2004	3. Time of Death
Examin		4e. Facility Name (If not institution	-			4b. City, Town, or	Location of Dea	ath	4c. Coun	ty of Deeth	
Funeral		MEMORIAL HOST  5. Social Security Number		A.STON 7. Age (In yrs.	last birthdav)	EASTO If Under 1 Year	N If Under 24 Hr	rs. 8. Date of Birth		ALBOT	ce (State or Foreign
Funeral Director		212-24-3918 Usual Residence of Decedent	1[ <b>X</b> M 2□ F	78	Yrs.	Months Days	Hours Mi		<sup>Y</sup> 1926	MA	KYLAND
how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				100	d. Inside City Limits
289-1 offiliar	Director	MD TALI	30T		EAS'						1 □ Yes 2√√ No
natural', or items 23a or 28e-f ehow digal Examiner rollat be notified at	Dir	10e. Street and Number 5982 MILLINGTON	JIANE			10f. Zip Code	1601	1	0g. Citizen of	f What Country USA.	y?
ems 2	Funeral	11. Marital Status	12. Was Dece		.S. 13.			(Specify Yes or No- erto Rican, etc.)		ace - American	
id other than "natural", or items 23a or 28e-f ehow event, the Medical Examinative rund be notified at	þ	1 Never Married 2 X Marri 3 Widowed 4 Divorced		2 🗍 No	1	1 ☐ Yes 2 ☐XNo	Specify:	erto Hican, etc.)	Spec	ack, White, etc. ify: WHI!	
lical E	eted	15. Decedent (Specify only highes	s Education		16a. Deced	dent's Usual Occupa	ation	norkina	16b. Kind of I	Business/Indu	stry
Die Mes	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work done a DO NOT use retired, ALTOR	)	orking	TANG	ESTATE	SATES
ent.	Be Co	17. Father's Name (First, Middle, L	<u> </u>		IX.	TILOR	18. Mother's Na	ame (First, Middle, A			DITTIME
natic e	ToB	EGBERT HOLMES		<b>L</b>	101 11 11			A PHELPS			
r traumatic event.	-	19a. Informant's Name/Relationsh  LOUISE S. HAWK						Rural Route Number, EASTON,	-		Code)
r othar tr		20a. Method of Disposition 1 Durial 2X Cremation	·		lace of Dispo	sition (Name of natory or other place	- 1			- City or Towr	n, State
jury o	4	' 4 □ Donation 5 □ Other (Sp	ecify)	late	SAPEAK	E CREMATI	ON CTR	1-29-2004	STEV	ENSVIL	LE, MD
eny injury or otl once.		21. Signature of Funeral Service L	icensee Masu	CFS	- 👂   F	Name and AddresELLOWS, H	ELFENBE	IN & NEWN. T EASTON,	AM FUN	ERAL HO	OME P.A.
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cannot one cause on ea	used the death ch line.	n. Do not ente	er the mode of dying	g, such as cardia	ac or respiratory arre	ist,	A	Approximate Interval Between Onset and Death
cian ical		Immediate Cause (Final disease or condition resulting in death)	a. Ry	r as a consequence	E	neep	halop	gatny			
ner			0 1	r as a consequ	uence ot):	reep.	10 G16	,			
) st	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	ras a consequ	uence of):						
	Examin	that initiated events resulting in death) Last	c. Due to (c	r as a consequ	uence of):						
	ca		d					· · · · · · · · · · · · · · · · · · ·			
	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna	ncy				22d D	ata of dolines.	inter-cere
	siclar	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2 Fetel nt at time of de		Ectopic pregnancy Other (specify)				ate of delivery onth Da	
		9 ☐ Unknown  Part II. Other significant condition			etting in the se	adach inn an an	- i- D-41	I age Dident		4-16- A- 4- 40-	(1, 110
	۵	CVVCAC	A+va		aiting in the un		піп Рапі.		acco use con s 2□No	itribute to the o	cause of death?
an pinotic y	ompleted							24a. Was an	24b.	Were autopsy	y findings available
5	Com							autopsy perform	ed?	prior to compl death?	letion of cause of
1	Be	25. Was case referred to medical examiner?	Hospital:			20 DOA Other	2	eath (Check only one	)		
	n: To	1 Yes & No.	28a. Date of	Injury	ER/Outpatient 28b. Time of	28c. Injury	at	Home 5 Resider			
	atlo	1 Accident 5 Pending investigation	ition	, Day Year)	Injury	Work' M 1□Y	? ′es 2 □ No				
	ertification;	3 Suicide 6 Could no 4 Homicide determin	288. Place 0	of Injury - At ho g, etc. <i>(Specify</i>	me, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Numi State)	ber or Rural R	loute Number,
	Medical C	29a. Certifier Check only one)	Physician: To the b	ils of examinat	wledge, death ion and/or inv	occurred at the time estigation, in my opi	e, date and plac inion, death occ	e, and due to the car surred at the time, da	use(s) and mate and place,	anner as state	ed. e cause(s)
	Med	29b. Signature and title of certifier	and manne	or stated.		29c. License	number	29	d. Date signe	ed (Month, De)	y, Year)
4		Denn	مل ل ن	Al	alo	000	05311	0 1	1291	12000	1
1				V	-				/ 1/		1
3		30. Name and address of person w						/		,	,
completely filled in by the funeral di		30. Name and address of person w  DENNIS DESHIELD 31. Date filed (Month, Day, Year)	S, M.D.		WASHIN	Print) NGTON ST I	EASTON,	MD 21601			,

		1 = For State Registrar	State of M	aryland / Dep <i>Ce</i>		nt of Hotel		nd Mer			4 04416
Physici	an	1. Decedent's Name (First, Middle, La Marion Kentz Hea						-	Date of Deat Month	Day Year	3. Time of Death
/Medio					1				anuary		4:00 pM
Examir	ier	4a. Facility Name (If not institution, gir				_	Location of E	Death		4c. County of Dea	
		Larkin Chase Nu: 5. Social Security Number 6.		e (In yrs. last birthday		Bowie	If Under 24	Hrs. 8.	Date of Birth	9 Bi	George's
Funeral Director				90 Yrs.		Days	Hours	Min. Au	(Month, Dey 1gust 8	3,1913 Was	hington, D.C
within 72 hours after death with the Maryland liene. r then "natural", or Items 23s or 28s-f show the Medical Ezarta at must be motified at	ctor	10a. State 10b. County Virginia Arling	ton	10c. City, Town or L Arlingto							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with the	al Director	10e. Street and Number 404 N. George Ma	son Drive,	Apt. #1	10f. 2	ip Code 22203	3		1	0g. Citizen of What C U.S.A.	Country?
E E	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Dec	edent of His	spanic Origin n, Mexican, F	? (Specify	Yes or No- an, etc.)	14. Race - Am Black, Wh	
ral', or its	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 X If Yes, Give Year or Dates:			2 <b>∏</b> No	Specify:				White
netu	etec	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Dec	edent's Us e kind of v	ual Occupa rork done d	ition u <i>ring most o</i> i	f working		16b. Kind of Busines	s/Industry
within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or				Assis		]	Department	of
ital Hyg od othe	Be	17. Father's Name (First, Middle, Las Eric Kentz	1)	- Tidin I I	11001		18. Mother's	Name (Fi	irst, Middle, I	Agricultur Maiden Sumame) Lackman	e
and z should be ri ealth and Mental H m 27 is marked otl ter treumatic ever	To	19a. Informant's Name/Relationship Gail L. Fleshman								City or Town, State,	Zip Code)
- I i i i		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (N	ame of	e)	Date		20c. Location - City o	r Town, State
nent of hands. If its		1 ☑ Burial 2 ☐ Cremation 3 ( 1 ☐ Donation 5 ☐ Other (Spec		Rock Cre				30/20	004	Washington	n, D.C.
permit. rages Department of Important: If I any injury or once.		21. Signature of Funeral Service Lice		1 .			s of Facility			neral Hom	
hysician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. RESI	d the death. Do not eline.	nter the m	ode of dying	g, such as ca		spiratory arro		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed to the law requires that has been signed by the attending physician and the latter of	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SPS (Due to (or as	a consequence of):	î.E	Ax	624	EST	n E P	54	>ONE Y
at the death certificate by the attending physicached for use as the tached	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic □ Other (	pregnancy specify)				23d. Date of di Month	elivery Day Year
puires that signed b ild be deta	by	Part II. Other significant conditions	contributing to death to	The same of the sa	underlying HA	cause give	on in Part I.				to the cause of death?  Probably 4 Dunknown
cate has been si	Completed	EPILEPS	4.	b				- 1	24a. Was a autops perform	v prior to	autopsy findings available completion of cause of
	e Co	25. Was case referred to medical					26 Place of	f Dooth (C	1 ☐ Yes :		9s 2 No
sician: certific irector,	80	examiner?	Hospital: 1 Innati	ent 2 ER/Outpatio	ent 3 🗆 i	Othe				ence 6 Other (Sp	necify)
After this funeral dis	tion: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time	of	28c. Injury Work		28d		ow injury occurred	·
in the nospirer of Attended by Trystocent, within 24 hours after death.  To the Funerel Director: After this certification pletely filled in by the funeral director,	Certification:	Accident investigation     Suicide 6 Could not determine	28e. Place of In	jury - At home, farm, s tc. (Specify)	treet, fact	ory, office		28f.	Location (St City or Town	reet and Number or f n, State)	Rura <i>l Route Number</i> ,
	edical C			of my knowledge, dea of examination and/or lated.							
within 2 To the	₩	29b. Signature and title of certifier	0		2	9c. License	number	_	2	9d. Date signed (Mor	nth, Day, Year)
(14)		<b>&gt;</b> 819		D'		D. 3	545	25		January 28	
100		30. Name and address of person who	no: 400	oo-mito	Print)	ville	Ro	ad=	+220	Bowie	mp-20766
St Regist	ate	31. Date liled (Month, Day, Year)	32. Regist	rar's Signature	B						

rald Hin	es	1 - For State Registral MEND ITEM #5	State of Maryla						giene 2 Reg. No.	004	04417
Physici	ian	1. Decedent's Name (First, Middle, La	st)	OT DIE				2. Date of De Month	aath Day	Year	3. Time of Death
/Medi			NES		T 63 T-		ti1 D	Januar		004 inty of Death	638_a <sup>™</sup> _
Examir	ner	4a. Facility Name (If not institution, giv			1		ocation of Do arlbor			nce Ge	
<u> </u>		13404 Trumpeter S 5. fpgal & cuyty Nymber 6.5		s. last birthday	If Under 1	Year	If Under 24 h	Irs. 8. Date of Bir			place (State or Foreign ntry)
Funeral Director			⊠M 2□F 46	Yrs.	Months [	Days	Hours M	1in. (Month, Da 8 16	1957	New	York
ryland show	_	10a. State 10b. County	10c. 0	City, Town or L	ocation						10d. Inside City Limits  ↑ Yes 2 □ No
8a-f	Director	MD Prince G	eorge's	Upper	Marlbo				10g, Citizen	-4.14754.00	
with the	Dire	10e. Street and Number 13404 Trumpeter	Swann Court		10f. Zip Co	ode 1744			•	S.A.	nuy?
oms 23	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder If Yes, specify	nt of His Cuban	panic Origin? , Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	p- 14. l	Race - Ameri Black, White,	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. The maturel, or items 23s or 28s-f show ent, the Mydical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:		1 ☐ Yes 218	No	Specify:		Spe	ecity:	31ack
72 hor	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual ( kind of work of DO NOT use	Occupat done du	ion iring most of	working	16b. Kind o	f Business/Ir	ndustry
d within 72 hours at glene. or then "natural", or	Juno	Elementary/Secondary (0-12)	College (1-4or 5+)		n Opera				Gove	rnmen	t
d 2 should be filed th and Mental Hygi t7 is marked other traumatic avant.	Be Co	17. Father's Name (First, Middle, Last	)					Name (First, Middle	, Maiden Sun	name)	
should be nd Mental marked o	ToB	Charles Porter	Hines				Rosa		Burns		
d 2 shoulth and Miles I is mark		19a. Informant's Name/Relationship (Miriam D. Hines						r Rural Route Numb in Court (			p <i>Code)</i> ro, Md 2074
Heal Heal ther		20a. Method of Disposition		. Place of Disponentery, cre	osition (Name matory or othe	of er place	)	Date	20c. Location	on - City or T	own, State
Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	Removal from State	esurrec	tion Co	eme.	2-	-2-2004			ryland
permit. Pag Depertment Important: It any injury o		21. Signature of Funeral Service Lice	nsee					J. B. Jer ad Landov			
Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	polications that caused the defone cause on each line.	AB (	ter the mode of	of dying,	such as care	diac or respiratory a	irrest,		Approximate Interval Between Onset and Death
ificate be executed  g physician and as the burial-transit	icai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const  Due to (or as a const  c. Due to (or as a const  d	equence of):							
ath certific titending pl or use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	⊒Ectopic preg □ Other (spec				23d.	Date of deliv Month	rery Day Year
res that the de signed by the a l be detached t	by	Part II. Other significant conditions	contributing to death but not r	esulting in the i	underlying cau	ıse giver	n in Part I.		tobacco use o		the cause of death?
he law requires t has been signe ige 2 should be	eted							24a. Was	/\		opsy findings available
	Completed							auto		prior to co death? 1 De Yes	ompletion of cause of 2□ No
iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Cthor		Death (Check only	25.0		
Phys this ral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	t ☐ Inpatient 2  28a. Date of Injury (Month, Pay Year)	ER/Outpatie	KUNN 280	. Injury Work	at	28d. Describe	how injury oc	curred 5 U	wat scene BJUT
I or Attending after death. Director: After I in by the fune	catic	2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not I	on 1/24/04	062	YA M	1 🗆 Y	es 2 000		SED SE	•	m I Davita Alumbas
To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined		home, farm, si	treet, factory, o			City or To	wn, State)	3404 27, UPPK	TRUMPETER TRUMPETER AMARIBARO,
To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, dea ination and/or i	th occurred at nvestigation, in	the time n my opi	e, date and pl inion, death o	lace, and due to the	cause(s) and	manner as	stated.
To the within 2 To the comple	Me	29b. Signature and title of certifier	11.			License	number		29d. Date si	gned (Month, ary 25	
$(\eta)$		30. Name and address of person who	completed cause of death (II	tem 23a) (Type	, Print)	. D.	on Ct-	root Pol+			
	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sig	nature -		L Pe	nn Str	eet, Balt	тиоте,	LIGT A	land 21201
Regist		JAN 3 0 200		4 Soc	de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#20bperFHG
For 828 2/12/04 EW State of Maryland / Department of Health and Mental Hygiene
Registrar Amend Item#29dperPHYG828 2/9/04EW Certificate of Death
Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1351 2004 January ELIZABETH ANN HAYNES જ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | 1 Icel bot Hospita Memoria 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Sept.10,1940 63 Maryland 219-36-7197 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County in than "netural", or Itams 23s or 28s-f ehow the Medical Examiner must be notified at 1 MYes 2 □ No **Funeral Directo** Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 208 so. 8th Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. ģ 3 X Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 21215-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clifton Cannery 8 Line worker f Health and Mental Hygie Item 27 is marked other i other traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland Be Beatrice Roberta Thomas 2 William Emerson Baynard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Caroline Apt. 203, so. 8th Street, Denton, Md, 21629 Robert Baynard / Son other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/15/2004 permit. Pages 1
Depertment of H
Important: If Ite
any injury or ot 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 10/15/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bennie Smith Funeral Home

426 Dover Street, Easton, M.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 426 Dover Street, Easton, Maryland 21601 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Resperitory failure Physician /Medical Due to (or as a consequence of): **Examiner** OSDErotoun Dreumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tamponade 1 Ø Yes 2 □ No 3 □ Probably 4 □ Unknown Completed metastatic Head and neck concer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No certificate Vital 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this o After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Hospital or Attending 5 Pending investigation Division .ospital c. 4 hours after deals. ~al Director: After 1: Natural 1 ☐ Yes 2 ☐ No 2 Accident fo the . within 24 hour. > the Funeral Dire. 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29e. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 55484 1/30/2004 HL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H.L. Jin, M.D., 219 So. Washington Street, Easton, Maryland 21601 State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

9

プロフゴ土

29

State of Maryland / Department of Health and Mental Hygiene 🤈 04419 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Frederick 7, **Physician** 2004 5:15pm M Hefren Hollingsworth Sophia Josephine /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4335 Ijamsville Road Ijamsville Frederick If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 238-01-0645 Jun 21, 1915 North Carolina 88 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle | other traumatic event, the Medical Examiner must be notified at Ijamsville Maryland Frederick 1 ☐ Yes 2X No Directo 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 21754 U.S.A 4335 Ijamsville Road Funerai 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours after inent of Health and Mental Hygiene. ant: If Item 27 Ie marked other than \*natural; or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hefren Josephine Augustine Wayne Augusta 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs Marjorie Schroeder/Daughter 4223 Ijamsville Road, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot ance. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State St Joseph's Cemetery Feb 11, 2004 Buckeystown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tup of Funeral Service 22. Name and Address of Facility Keeney & Basford Funeral Home 106 East Church St, Frederick, shock, or heart failure. List only one cause on each line. Maryland 21701 Approximate Interval Between Onset and Death tmmediate Cause (Finat **Physician** Squamous Cell Cancer of Tongue Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hypothyroid Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Osteoporosis : Alter this certifical funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2€ No 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1x Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 February 9, 2004 (7 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Casper E. Cline, III, 300 West Ninth Street, Frederick, maryland 21701 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 2 2004 Registrar

Description from Company Price states (Price & Mode). 2   2.5 p. Mode)    The Part of the Company of the Compan	Prysician Medical Examino Function Func		**			1- State of Ma Registrar		partment of Healt ertificate of Dea		rgiene Reg. No 2004	04420
## Feligy Name of Not Machinon, John Series and mumbers Hart Ford Memoral and Hospital Hart Ford Memoral and Hospital Hart Ford Memoral and Hospital Hart Ford Memoral and Hospital Hart Ford Memoral and Hospital Hart Ford Memoral and Hospital Hart Ford Memoral and Hospital 1255-50-1126 1255-50-1126 1255-50-1126 1256-	Fundfall Fundfal Director Fundfal Direct		ŧ.			1. Decedent's Name (First, Middle, Last)	RETURE STATES	натт.	Month	Day Yeer	
Second Section Process   Section Process   Section	Harford Memorial Hospital    Harford Memorial Hospital   Harford Memorial Hospital   Discutor						DIBR				
25 - 56 - 712   10   10   10   10   10   10   10	Director    The content of the conte										
The part of the pa	Usual Residence of Diseased.  10s. States 10s. County 10s. States 11s. County 10s. States 14s. County 10s. States 14s. County 10s. States 14s. County 10s. States 14s. County 10s. States 14s. County 10s. States 14s. County 11s. Marcal Status					- W			irs Min (Month, D	av. Year) 500	เกตละe (State or Foreign ountry) ๆ คำ หา่ ค
1	Specify: White    Committee			ס		Usuel Residence of Decedent				2)-1 1044	
1	Specify: White    Committee			arylar show	7		10c. City, Town or				
1	Specify: White    Committee			the M	ecto				erryman	10g. Citizen of What C	ountry?
1	Specify: White    Committee			h with	io is	4		21	.130	United S	States
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as			r deat	ner	11. Marital Status 12. Was Decedent E- Armed Forces?	ver in U.S.	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mer</li> </ol>	o Origin? (Specify Yes or Nician, Puerto Rican, etc.)	o- 14. Race - Am Black, Whi	
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as		36	rs afte	y Fu	If Yes, Give	5	1 ☐ Yes 2 <b>X</b> No Spe	cify:	Specify:	White
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as		9	2 hou	ted	15. Decedent's Education	16a. Dec	cedent's Usual Occupation	most of working		
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as		215	ithin 7 ne. nen "n	nple	Elementary/Secondary (0-12) College (1-4or 5+	+)				
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as		721	Hygier Hygier ther th	Co		1 12				Bel Air
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as		land	id be i ental I ked o	o Be		Hal	11	Zella M	Iae Cr	regger
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as	(	ary	and Mand is mar	-	· ·	19b. Ma	ailing Address (Street and No			
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as	R	Σ,	and 2 lealth m 27 her tr			420 20h Place of Dis	D Busby Dri			The same of the sa
Physician Modifical Examinor  TO A By Date of Cortacle and Section of Cortacle and	Physician Medical Examiner  Physician Medical Examiner  O. G. G. S. S. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Condition or suiting in death)  Due to (or as a consequence of):  Due to (or as	76	more	Pages 1 ent of H nt: if ite ry or ot		1 Burial 2 □ Cremation 3 □ Removal from State					
Physician Model  20a Pant, Errer the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arest, immediate Cause (Final disease) or complications that coursed the death.  20a Dust for as a consequence of):  20a Dust for as	Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Part (Medical Examiner)  P	e x	Balti	permit. I Departm Importer any inju		A 4		22. Name and Address of F	acility Jarrett	sville, N	laryland
Physician Medical Skeminer    Physician Medical Skeminer   Physician Residence   Physici	Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Immedi	2				23a. Part1. Enter the disease, or complications that ceused shock, or heart failure. List only one cause on each life	ne death. Do not e	enter the mode of dying, suc	h as cardiac or respiratory	arrest,	Approximate Interval Between
Due to (or as a consequence of):    Court   Cause   Ca	Due to (or as a consequence of):    Condition of the cond					Immediate Cause (Final disease or condition	ito 1	Myo Cand	ial Info	nctum	Onset and Death
The part of the	Due to (or as a consequence of):    Color   Co		Н			Due to (or as a		1		A d =	
The particular of the part of	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Close of the control of the control of the cause of death of the cause o				ē	if any, leading to immediate Due to (or as a		Cerolic (	and 1. vonc.	Van anagre	
The part of the pa	d.    Composition of the past 12 months?   Composition of the past 12 months?   Composition of cause given in Part I.   Composition of cause of death of the past 12 months?   Composition of cause given in Part I.   Composition of cause of death of the past 12 months?   Composition of cause given in Part I.   Composition of cause of death of the past 12 months?   Composition of cause of death of the past 12 months?   Composition of cause given in Part I.   Composition of cause of death of the past 12 months?   Composition of cause given in Part I.   Composition of cause of death of the past 12 months?   Composition of cause of death of the past 12 months?   Composition of cause given in Part I.   Composition of cause of death of the past 12 months?   Composition of cause given in Part I.   Compos			cuted nd ransit	amin	cause. Enter Underlying Cause (Disease or injury that initiated events		olsluch	e Pylm	ong due	2
FEMALE   23d. Was decedent pregnant in the past 12 months?   12 mont	FFEMALE: 23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Yes   Ye	40	60,	be exe cian a burial-l	al Ex	Due to (or as a	. consequence of):			,	
Color   Colo	Sport of the state	7-	282		edica	d					
Color   Colo	Sport of the state	7	ŏ	h certi ending r use a	M/W	23b. Was decedent pregnant		3 □Ectopic pregnancy			•
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 Probably 4 Lucian autopsy findings and prior to completion of cause of death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.		-	0 0 D	ysicia	in the past 12 months?  1 □ Yes 2 □ No  4 □ Pregnant at t				Month	Day Tear
Comparison of the control of the c	1   Yes   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   3   Probably   4   Les   2   No   No	a n	۵	s that ined by	y Ph	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause given in F	Part I. 23e. Did	tobacco use contribute t	o the cause of death?
Comparison of the control of the c	24a. Was an autopsy findings are prior to completion of cat death?  25. Was case referred to medical examiner?  1   Yes   20 No    25. Was case referred to medical examiner?  1   Yes   20 No    26. Place of Death (Check only one)  Other: 4   Nursing Home   5   Residence   6   Other (Specify)  27. Manner of Death   1   Matural   5   Pending   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?	-	ords	equire en sig ould b	ted t	Soulie Cospination	1 /a	eline.	1	Yes 2□No 3□P	robably 4 Linknown
Comparison of the control of the c	25. Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   25.   Was case referred to medical examiner? 1   Yes   2   Ne   Yes   25.   Was case referred to medical examiner? 1   Yes   2   Yes	3	l Reco	The law rate has be page 2 sh	Somple	,	J J		auto	opsy prior to death?	completion of cause of
Comparison of the control of the c	1   Yes 2   New   North   1   Impatient 2   ER/Outpatient 3   DOA   Work?    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   28d. Describe how injury occur	th.	/ita	cien: ertifici	Be	examiner?		Oth	-		
Comparison of the control of the c	\ C P # C 1 Dratural 5 Pending (Month, Day Year) Injury Work?	EN	5	Physi rthis c ral dir	1.	1 Yes 2 New 1 Mempatien		IIII 3 DOA 4			ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)    ARMO-S. NAR. M.D. 601. S. Umin Que, Duried yes, Modicial	M 1 Yes 2 No	3	on	nding th. : Alter e fune	ation	Turatural Signatural	Year) Injury	y Work? M 1 ☐ Yes	2 🗆 No		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)    ARMO-S. NAR. M.D. 601. S. Umin Que, Duried yes, Modicial	7 S S S S S S S S S S S S S S S S S S S	22	Divis	l or Atter after dea Director in by the	ertifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injur		street, factory, office	281. Location City or To	(Street and Number or F own, State)	lural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)    ARMO-S. NAR. M.D. 601. S. Umin Que, Duried yes, Modicial	29a. Certifier  29a. Certifier			Hospita 24 hours Funeral tely filled		(Check only 2 Medical Exeminer: On the basis of	examination and/or				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)    ARMA-S. NAM. M.D. 601. S. UMICA QUE, Duried by S. MODICO.	29c. License number 29d. Date signed (Month, Day, Year)			To the within ?	Mec			10		29d. Date signed (Mon	th, Day, Year)
1 ARMO-S. NAR. MD. 601. S. Umin ave. Duredoyer, Mosion				1:		) Muy			10215	217/3	2004
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature				N				501. S. Um	in ave,	Dunedoy	Scot Con, Or
Registrar FER 1 2 2004	State A O OOC						ha .	books		·	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:05 P M 23, 2004 January Alice E. Ingham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1 □ M 2 🛣 F Yrs 90 21, 1914 389-28-8401 Wisconsin Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County r than "natural", or Itams 23a or 28a-f ehow It a Medical Examiner must be notified at 1 ☐ Yes 2 No Frederick Frederick Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21703 5970 Grove Hill Road death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: White Ď Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withingent of Health and Mental Hygiene. ant; If Item 27 le marked other than ury or other traumatic event, Item 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ole Brothen Gina Ne1son 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5970 Grove Hill Rd. Frederick, MD 21703 Jane Ingham / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-25-04 permit. Page Department of Important: N eny injury or once. Frederick Crematory Frederick 21. Signature of Funeral Service Licenses Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike Frederick, MD 21702 owthe e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each fine. Approximate Interval Between Onset and Death 23a. Part1. Enter the dishock, or heart fallu fmmediate Cause (Pind disease or condition resulting in death) Physician mass astric /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year Month for 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 TYes 2 🗌 No death. investigation 2 Accident after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide determined within 24 hours a To the Funeral I t 🔟 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 Registrar's Signature State 6 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 9:20 A M January 29 2004 Johnson Evelyn Agnes /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 3420 Thomas Bridge Rd Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sept 11,1932 Maryland Director 218-28-2405 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County 77 is marked other than "netural", or items 23a or 28a-f show treumatic event, the Medical Exercipal Internal be obtained at 1 ▼ Yes 2 No Director Maryland Caroline Greensboro 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 416 N Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumers. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Self-Employed Daycare Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Evelyn McDonough Rudolph V. Lerp Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Thomas Bridge Rd Street, Maryland 21154 Jeff Phipps son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 02/01/2004 Greensboro Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home PA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗌 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 ☐Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 ☐ Yes 2 **☑** No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 W ther (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide perili 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tiffs 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29+66 FAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 200 Registrar

CORRECTED 23b per physician Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 24 2004 Physician Marshall Dubois Jones 5:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Westernport Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 21 1918 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 214-07-3863 85 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "netural", or items 23a or 28a-f show The Madical Examiner must be notified at 10d, Inside City Limits Md.Allegany Westernport 1. Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 Poplar 21562 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Grocer 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any july or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dubois B. Jones Ida May Clise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Jones/ wife 308 Poplar St., Westernport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 01/27/ 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State Philos Cemetery Westernport Maryland ' 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 7. Wayne 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FAILURE ruralor 20 days /Medical Due to (or as a consequence of):-Examiner TRA TERMINAL ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. ф 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ CEREBRAL INTARC 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 Tes 2 No 1 ☐ Yes 2 ☐ No Division of Vital : After this certifica tuneral director, f 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG MID SATURNINA George Ereck S. W Frontleurg Marylang 21532 10701 Neu 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registra

	an	1- State cchd 1/27, Registrar Amend iter  1. Decedent's Name (First, Middle, L Darnell		2011			cksc			2. Date of De	Day	20° Y	3. Time of D
Medi	-									Januar		·	
xamir	ner	4a. Facility Name (If not institution, g		er)		_ *		Location o	of Death			County of	
30		Prince Georges 5. Social Security Number 6.		Ane (In vrs	last birthday)	Chev If Under 1			24 Hrs.	8. Date of Bir			Georges  Birthplace (State or I
neral ector		216-86-9317 Usual Residence of Decedent	1 <b>∑</b> M 2□F	34	Yrs.		Days	Hours	Min.	June 8	, 196	9 M	laryland
cilling at	Director	10a. State 10b. County  Maryland Prince  10e. Street and Number	Georges		y, Town or Lo	10f. Zip (	Codo				40- Civi		10d. Inside City
4		5619 Regecy Pa	rk Ct Ant	Q		207					_	SA	at Country?
Examiner must be notified at	by Funeral	11. Marital Status  1 Marital Status  1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force	nt Ever in U. s? XNo			ent of His	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 1	14. Race - Black, 1	American Indian, White, etc. Black
he Medical Exp	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12		or 5+)	(Give	dent's Usual kind of work DO NOT use	k done d	luring most )	of worki	-			ess/industry wo t of Publi
atic event,	To Be Co	17. Father's Name (First, Middle, Las Marshall	Jacks	son				Jerli	.ne	e (First, Middle,	Tol	lson	
other traum		19a. Informant's Name/Relationship Michael Jackson/E		20h B	3619-1	legene	Pe	ind Nymbe #3 ark C	t Ap		.tlan	d, Mar	yland 207
eny injury or ot once.		20a. Method of Disposition  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition  Disposition	eify)	1 0	Place of Disponentery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeters,	ion C	her place emet	ery 1	/26,	Oate /04			y or Town, State Maryland
eny in		21. Signature of Funeral Service Lice  Colors Office		МО	174	dans .		SHOWING THE PARTY		P.A. A	quaso	00, M	aryland
cian dical		23a. Part1. Enter the disease, or con shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	mplications that caus y one cause on each a	ed the death line.	uence of):	er the mode	of dying	, such as	cardiac c	or respiratory ai	rest,		Approximate interval Betwee Onset and De
ine purial-transit	dical Examiner	Sequentially list conditions, if any, leading to ummediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	UREO	uence of):	Syn	dro	ne					Week
detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pre					2:	3d. Date of Month	f delivery Day Yea
should be deta	by P	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying car	use give	n in Part I.		23e. Did to	_	1	te to the cause of dea
CV	Completed									24a. Was autop perfor	rmed?	24b. Wer prior deat 1	
ector	Be	25. Was case referred to medical examiner?	Hamitali > C						of Death	(Check only o	ne)		
al dir	2	1 ☐ Yes No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien			4 🔲 Nur		ne 5□Resid			Specify)
	ertification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatic 3 ☐ Suicide 6 ☐ Could not	(Month, L	Day Year)	28b. Time of Injury	М		at ? 'es 2 □ N	10	28d. Describe h			r Rural Route Numbe
y the funer	€ I	4 ☐ Homicide determined	building,	etc. (Specify	/)	on, raciory,	JIII O		Ī	City or Tou	m, State)	, tumber 0	TOTAL NOVIE NUMBE
filled in by the funer	O	4 Difficilia	husiaian Taria	A -4 I	.de de .								
comptetely filled in by the funeral director, page	Medical Certifi	29a. Certifier 1 X Certifying P	Physician: To the besiminer: On the basis and manner	of examinat	wledge, death tion and/or inv	estigation, i	t the time in my opi	inion, deatl	d place, a h occurre	and due to the dead at the time, d	cause(s) a date and p	and manne place, and	or as stated. due to the cause(s)

		1	For State Registrar	State of Mary		artmen <i>rtificat</i>			Mental H	lygien Reg. N	_ 211111	04425
			Decedent's Name (First, Middle, Las	t)					2. Date of	Death		3. Time of Death
	sician		James Horace Jol	nnson, Jr.					Janua	ry 2.	3, 2004°	6:20 P M
Market de	edical miner	_	ta. Fecility Name (If not institution, give Laurel Regional	•		1	Town, or	Location of Deat	h		c County of Death Prince Ge	
Fune Direc		5	5. Social Security Number 6. Sr 577-66-6790 1	ox 7. Age (In	yrs. last birthday, 55 Yrs.	If Under Months		If Under 24 Hrs Hours Min.	8. Date of (Month, Augus	Birth Day, Yea	9. Birth Cou	place (State or Foreign intry) SHINGTON, DC
Ţ.		-	Usual Residence of Decedent									
Marylar a-f show	ptor		10a. State 10b. County  1ARYLAND PRINCE G		BOWIE	ocation						10d. Inside City Limits  XXYes 2 □ No
ith the	Director		10e. Street and Number			10f. Zip	Code			10g. C	Citizen of What Cou	intry?
ath w	E	1	3228 TENTH ST.			207					CED STATE	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked or other then "natural", or Itams 23e or 28e-1 show the trainmain event the Mental Mental in the propriet of the control of t	by Funeral	7	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes XX No If Yes, Give	in U.S. 13.	Was Deced If Yes, special 1 Yes	cify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or to Rican, etc.)	No-	14. Race - Ameri Black, White, Specify: BT.	
2 hours	P	2	XXWidowed 4 □ Divorced  15. Decedent's Ed	Year or Dates: ucation		dent's Usua				16b.	Kind of Business/Ir	
21215-0036 3d within 72 hours aff giene. or then "natural", or	Completed	2	(Specify only highest gra		(Give		rk done d	during most of wo	rking	, , ,		
d 212 filed with Hygiene.	5		47 F-Ab-d-Alam (Fine Asiddle 1 A)	2YRS	. <u>M</u>	ANAGE	R	40.14-11-1-11-11			PRIVATE	
Maryland of 2 should be file the and Mental Hy 27 Is marked oth	8	í	17. Father's Name (First, Middle, Last)	OM GD				18. Mother's Na			an Sumame)	
Taryland 2 should be f and Mental H Is marked of	1		JAMES HORACE JOHNS  19a. Informant's Name/Relationship (7)		19b. Maili	ng Address	(Street a	ANNIE B			or Town, State, Zij	o Code)
Battimore, Ma permit. Pages 1 and 2: Department of Health as Important: If Item 271s		11)-		THER	507 4	2ND S	ST. N	ORTHEAST	WASH	INGT	ON, DC 2	0019-8035
Saltimore, sernit. Pages 1 a Department of Heam profession in the moortant: If the movinity of other	5	1	20a. Method of Disposition XX Burial 2 Cremation 3	Removal from State	Ob. Place of Dispo cemetery, cre	matory`or o	ther place	· 1	Date		Location - City or T	
IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Vicen	see \	MOUNT OL						ASHINGTO	
E Ped E	ouce		<b>)</b>	arish II	MZ	ARSHAI		FUNERAL AND ROAD			RYLAND, II	
Physici	an	- 1	23a. Part1. Fiter the disease, or compshock, it heart failure. List only immediate Cause (Final disease or condition	olications that caused the one cause on each line.	death. Do not en							Approximate Interval Between Onset and Death
/Medic Examin	_		resulting in death)	Due to (or as a co	nsequence of):							
	- a	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Kidney F  Due to (or as a co								
760, be executed sician and	Examiner		cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes	Mellitu	S						
50, e exec	Exa		resulting in death) Last	Due to (or as a co	•							
<b>68 / 60,</b> ificate be exerging physician as the burial.				d. Hyperten	sion							
O. Box the death cert the attending	by Physician/Me	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pr □ Other (sp				-	23d. Date of deliver Month	ery Day Year
of Vital Records, P. Physician: The law requires that: This certificate has been signed by tail circuity, page 2 should be deals	3 5		Part II. Other significant conditions or	ontributing to death but no	t resulting in the u	nderlying c	ause give	en in Part I.	- 10		use contribute to t	he cause of death?
ecord law requir as been si	1 0								24a. W		24b. Were auto	ppsy findings available
On of Vital Rec ding Physician: The lav h. After this certificate has									pe	topsy rformed? XXIN	death?	impletion of cause of 2  No
Of Vital F Physician: Th this certificate	Be	3	25. Was case referred to medical examiner?	Hospital	10		104	26. Place of Dea	ith (Check onl	y one)		
Physical Children	L		1 ☐ Yes XX No 27. Manner of Death	Hospital XIX Inpatient 28a. Date of Injury	2 ER/Outpatier			4   Nursing F	ome 5 Re		6 ☐Other (Special	(y)
ding Alte	loi		XX Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	м	8c. Injury Work	? res 2 □No	200. 0030110	e now mp	ary occurred	
# # # # E	Certification:		3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stroecify)	reet, factory	, office		28f. Location City or 1	(Street a	and Number or Rura te)	al Route Number,
DIVISI  To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	edical C		29a. Certifier XXX Certifying Ph	ysician: To the best of my liner: On the basis of exa and manner stated.	rknowledge, deat mination and/or in	h occurred vestigation	at the tim	e, date and place pinion, death occu	, and due to the rred at the time	e cause( e, date ar	s) and manner as s nd place, and due to	stated. o the cause(s)
To th withir	N N		29b. Signature and title of certifier	un ste	udiug		D425				ate signed (Month, -23-04	Day, Year)
R/5			30. Name and address of person who o	completed cause of death								
			P.S. AUJLA 31. Date filed (Month, Day, Year)	Ann Cantinum C		2 Ann	apol:	is Rd. #	13 Blac	iensb	ourg, md	20710
Reg	State jistrar		JAN 3 0 2004	32. Registrar's S	K Long	Es .						

DHMH 17 Rev 1/2001

JAMES JOINGOS X-3/-194

06	53			State of Ma				-	_	
			1 - For Unpend Item#23.		r me G828 272	difficate of	Death			04426
	Physicia	an	Decedent's Name (First, Middle, L.					2. Date of Death Month	Day Year	3. Time of Death
>	/Medic	al .	Michael  4a. Fecility Name (If not institution, gi	Kalbaugh		4b. City. Town, o	r Location of Death	JANUARY	4c. County of Deeth	0830 A M
	Examin	er	1502 OLDTOWN MAN			CUMBERL			ALLEGANY	
	Funeral				e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 3	Year) 9. Birth	place (State or Foreign ntry)
	Director		220-70-4000	1 <b>⊠</b> M 2□F	56 Yrs.			March 3	1 1947 West	Virginia
	land	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary	to	MD. Allega	ny	Cumberl	.and				t <b>X</b> Yes 2 ☐ No
	or 284	Director	10e. Street and Number	_		10f. Zip Code	_		g. Citizen of What Cou	
	ath w		1502 Oldtown M			21502			nited State	
	Items	by Funeral	11. Marital Status  1   ↑ Never Married 2   ↑ Married	12. Was Decedent Armed Forces? 1 Yes 2 2	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,	etc.
036	al', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>∑</b> ANO	Specify:		Specify: Whi	.te
2-0	filed within 72 hours after death with the Maryland Hygien. ther than -natural; or Items 23s or 28s-f show ent, Its Medical Examiner must be notified at	Completed	15. Decedent's 8 (Specify only highest g	Education grade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of work d)	ing	6b. Kind of Business/Ir	dustry
12	within ane. than	mp	Elementary/Secondary (0-12) unknown	College (1-4or 5	0+)	DO NOT use retired never worl	-		none	
ე ე	filed Hygid Sther ent,	Be Co	17. Father's Name (First, Middle, Las	st)		.0.0101	18. Mother's Name	e (First, Middle, M		
ılan	should be and Mental a marked o	To B	Victor Kal	baugh			Amy Re	egina O	'Neill	
Maryland 21215-0036	0 0 = 0	•	19a. Informant's Name/Relationship						City or Town, State, Zij	
<b>≥</b>	1 and 1ealth om 27 ther tr		Amy Regina Kalba  20a. Method of Disposition	ugh/ mother	20b. Place of Dispo		and the second second	-	on, Marylar Roc. Location - City or T	
Baltimore,	permit. Peges 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☐ Burial 2 ☑ Cremation 3		Cumberlar	matory or other place	<sup>(θ)</sup> 11/	24/ C	umberland M	
at:	nit. P vartme ortan injury		*4 □Donation 5 □Other (Spec 21. Signature of Funeral Service-Lice			2. Name and Addre	200	-	neral Home	
ä	permit. Departr Importa any inj		> 7 Way	ne Br		111 Churc	ch St., We		rt, Marylan	d 21562
			23a. Part 1. Enter the disease, from shock, or heart failure. List only	mplications that caused by one cause on each li	d the death. Do not ent ne.	ter the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
ď	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEIZURE D	ISORDER					Oliset and Death
<i>R</i> .	/Medical Examiner		( )	Due to (or as	a consequence of):					
4		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C					(1)	
760,	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
6876	4 E E	Physician/Medical		d						
Box 6	certif rding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	ery
	0 0	iciar	in the past 12 months?	4☐Pregnant at		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>	/		Month	Day Year
P.0.	at the by th	hys	9 🗆 Unknown	9□ Unknown						
	56 00		Part II. Other significant conditions HYPERTENSIVE CARDIO	_	•	, ,	en in Part I.	23e. Did tob	acco use contribute to t s 2 Soo 3 ☐ Pro	he cause of death?
oro	w require been si should t	eted	HILIMITADIAE CHIDIO	VASCULAR DISE	ASE REPAILITS	<u> </u>				
Rec	The law cate has page 2 s	Completed by						24a. Was ar autopsy perform	y prior to co ned? death?	opsy findings available ompletion of cause of
Vital Records,		a)	25. Was case referred to medical				26. Place of Deat	1 Check and and	1 / 4	2 No
Ž	× 5	To B	examiner? 1∑Yes 2□ No	Hospital: 1 Inpatie	ent 2 ER/Outpatier	nt 3 DOA Oth			nce <b>§</b> {☐Other (Speci	MAT SCENE
n of	ng Ph (fer th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary 28b. Time o lnjury	Wor		28d. Describe ho	w injury occurred	
sio	Attending r death. ector: After y the fune	cati	2 Accident investigate 3 Suicide 6 Could not	ho	ive. At home form		Yes 2 □ No	29f Location /Str	reet and Number or Run	al Coute Alumbar
Division	after of Direct In by	Certification:	4 Homicide determine	building, et	ju <b>ry - At home, farm, st</b> tc. <i>(Specify)</i>	reet, factory, office		City or Town	, State)	ar House Number,
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 ☐ Certifying I	Physician: To the best	of my knowledge, deat	h occurred at the tir	me, date and place,	and due to the ca	use(s) and manner as	stated.
	the Ho in 24 I the Fu pletek	edical	(Check only 2 Medical Ex-	aminer: On the basis o and manner st	of examination and/or in ated.	vestigation, in my o	opinion, death occur			
	To the I	Σ	29b. Signature and title of certifier	1 11		29c. Licens	e number ME		od. Date signed (Month, JANUARY 24,	
			A				A 111		DENOMINE 44,	2004
			30. Name and address of person wh			·	Dolleime	n Maria	~~~ 11201	
	Sta	ite	31. Date filed (Month, Pay, Year)		rar's Signature	A La	Datrimor	e, maryl	and 21201	
	Registi	rar	Sall & D	2007	100 B 19	Design 1				

		- State Registrar		Co	ertificate o	f Death		, No. 2004	U444	
hysicia	ın	1. Decedent's Name (First, Middle, Las Charlotte		Kenne			2. Date of Death Month	Day Year	3. Time of Death	
/Medica	al		Marie	Kenne				1, 2004	11:55 a	
Examine	er	4a. Fecility Name (If not institution, give Hebrew Home	street and number)			or Location of Dev ville	120			
morel		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthda			rs. 8. Date of Birth	Montgomer		
neral rector		235–18–7368 Usuel Residence of Decedent	□M 2X)F	89 Yrs.	Months Day	s Hours Mi	March 29,	(ear) 9. Birth 1914 Virg	ginia	
show det	_	10a. State 10b. County Maryland Montgomer	• 7.7	10c. City, Town or Rockvill					10d. Inside City Limit	
28a-r	recto	10e. Street and Number	· y	ROCKVIII	10f. Zip Code		100	. Citizen of What Cou		
23a o	a	6121 Montrose Roa	ıd		208	52	U	SA		
E E	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Bleck, White		
or other train instead by inertia con or coart and event, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X 1 If Yes, Give Year or Dates:	40	1 ☐ Yes 2X N			Specify: Whi		
Medical	pletec	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Giv	edent's Usual Occ re kind of work don DO NOT use reti	upation e during most of w red)	orking 16	b. Kind of Business/Ir	dustry	
4	E	12	College (1-40) 2	wa	itress			restaurant		
ilc event,	To Be C	17. Father's Name (First, Middle, Last) Aljourn F. Jenkt	ns				ame (First, Middle, Ma n E. Reid	iden Sumame)		
traum		19a. Informant's Name/Relationship (T) Geraldine M. Tsili					Rural Route Number, C			
other	1	20a. Method of Disposition			position (Name of ematory or other p			c. Location - City or To		
		1 ABurial 2 Cremation 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Removal from State		ematory or other p. ron Ceme 1		'05/04 W	inchester,	VA	
Important: If any injury or once.	1	21. Signature Foneral Silver Licens			22. Name and Add	ress of Facility M	ichael R.	Phelps & A	ssociates	
3	1	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused					-	Approximate	
cian lical		Immediate Cause (Final disease or condition resulting in death)	. AWTE	a consequence of):	CARDIA	te INF	ARCT701	1	Interval Between Onset and Death	
niner	e.	Sequentially list conditions,	b. Due to (or as	a consequence of):						
transit	Examin	Sequentially list conditions, any, leading to ammodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C							
ysicia ne bur	ca	rosaling in doday, East	d	a consequence of);			NT TAX			
attending pny	n/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of delive	ery	
detached fo	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		☐Ectopic pregnan☐ Other (specify)	су		Month	Day Year	
	by P	Part II. Dther significant conditions co	ntributing to death be	ut not resulting in the	underlying cause g	iven in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?	
d bluods	ed t	DEMENTA	4				1 🗆 Yes	2 No 3 Prot	ably 4 Unknow	
nas been je 2 shoul	Completed						24a. Was an autopsy		psy findings availabl	
page	E						performe	d? death?	mpletion of cause of	
ō	Be	25. Was case referred to medical examiner?				26. Place of De	eath Check onl one			
ō ,	2	1 Yes 2 100	lospital: 1 🗌 Inpatie	nt 2 ER/Outpatie	ent 3 DOA	ther: 4 Unirsing	Home 5 Residence	e 6 Other (Specif	y)	
e funer	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Da)	y Year) 28b. Time Injury	W	uryat ork? ]Yes 2 □No	28d. Describe how	injury occurred		
d in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ary - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,	
	Medicai C	29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exami	sician: To the best on nar: On the basis of and manner sta	examination and/or i	ith occurred at the nvestigation, in my	time, date and place opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as s and place, and due to	ated. the cause(s)	
lomos	Me	29b. Signature and title of certifier	a)	1	29c. Licer	ise number	29d.	Date signed (Month,	Day, Year)	
_		1 / degra a	Commi	MI	D2	-4947	7	FEB ROCKVILLE	1 2004	
m	-	30. Name and address of person and co	7	eath (Item 23a) (Type	5:0	77 23 21				

				State of Mar	yiaiiu /	Certific				Reg. No. 2	006	0442	5
	Dhuaiais		1. Decedent's Name (First, Middle, Last)				_		2. Date of De Month	eth Dev	Year	3. Time of Death	-
~	Physicia /Medic		Martha Cannon La	rimore					Januar			12:42 AM	
)	Examin		4a Fecility Neme (If not institution, give s	street end number)			4	4b. City, Town, or	Location of Deat	4c. County	y of Deeth		
			Ruxton Health of I					Denton			oline		
۵	Funeral		5. Social Security Number 6. Sex	IM 2√2 F	In yrs. lest b	Yrs. If Ur Mont	hs Deys	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Year)	9. Birthp	olece (State or Foreign ntry)	1
	Director	-	215-26-5524 Usuel Residence of Decedent	A	72	113.			Januar	y 5,193	2 M	aryland	_
dand	<b>8</b> #		10a. Stete 10b. County	1	Oc. City, Tov	wn or Location					1	0d. Inside City Limits	_
Men	무를	इं	Maryland Caroline	,	Gree	nsboro						1 ☐ Yes 21 No	
the	25 E	Director	10e. Street end Number	<del></del>	OFCC		Zip Code			10g. Citizen of	What Cour	itry?	_
h wit	23a or 28a-f show wat be notified at		12584 Knife Box Ro	ad			21639			U.S.A.			
deet	Roms (	Funeral		12. Was Decedent Eve	er in U,S.	13. Was De		ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No		ce - Americ		
DOCO	al', or its Examine	ρ	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				Specify:	o Hican, etc.)		ck, White, y: whit		
<b>3</b> 5	'natural', dical Exp	Completed	15. Decedent's Educ (Specify only highest grade	cation	168	a. Decedent's U	Jsual Occup	ation during most of world)	rkina	16b. Kind of B	usiness/Ind	dustry	_
Z ig		힐	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO	Tuse retired	t)	King				
Q P	ygien t. T	ခွ်	12	1	as	sistant	cust	omer rep				acturing	
<b>三</b> 8	d off	Be	17. Father's Name (First, Middle, Lest)						ne (First, Middle,	Maiden Surnar	ne)		
2 2 2	Merke	<del>န</del>	James Earl Cannon		-	- 01111 11101			e Drews				_
<b>≅</b> ∾	0 9 5		19a. Informant's Name/Relationship (Type	oe, Print)				and Number or Ru					
a -	I S S	1	Herman Larimore  20a. Method of Disposition	spouse		2584 Kn			reensbo	ro, MD  20c. Location	21639		_
	or in the		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		of Disposition (i		1			•		
_	- 4 -	1	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		Green	sboro C		ry 0 ss of Facility	1/27/200	4 Gree	ensbor	:o,MD	_
0 E	Dep amy amy any	ļ	14 14			Fleegl	Le and	Helfenb	ein Fun	eral Hor	ne PA		
		-	23a Part 1 Enter the disease or compli	constitute that the	a death. De	PO Box	x 160	Greensb	oro, Mar	ryland	21639	9 Approximate	_
DI	waisian		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.	e death. Do		2	g, such as cardiac	or respiratory ai	rest,		Interval Between Onset and Death	
	Medical		Immediate Cause (Final	Mol	nota	tion	1.	00 60	100 210	4		1 UP	
* E:	kaminer		disease or condition resulting in death) a.		e to (or as a	consequence		ngca	VCOM	Ma	1	/ //	_
77	*	ne			0 10 (01 20 2	· comocquomoc ·	J.,.	0			1		
ecute	physicien end	Examiner	Sequentially list conditions,  Due to (or as a consequence of):										_
Š Š	cien	<u></u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):										
Sete	the t	edical	that initiated events resulting in death) Last  Due to (or as e consequence of):										
Sertifi			d.								ŧ		
a ta	for u	اق									1		_
je di	y the	by Physician/N	Part II. Other significant conditions cont	1	Mary Control	1						the cause of death?	
the T	d bete	<u>~</u>	Chronic Obstructure pulmonandescase 1200 3 Probably 401										n
w requires	n sign				/		-	_	24a. Wes	an autopsy	24b. We	re autopsy findings	
	sho :	Completed							perfo	med?	con	allable prior to inpletion of cause death?	
F 8	age 2	Ē							101	es XIII		Yes 2□ No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours enter deeth.  To the Hospital or Attending Physician: The law requires that the death certificate be executed became and the control of the standard of the control	tor, p		25. Was case referred to medical					26. Place of Dea	th (Check only o		1		
	direc	9	examiner?	ospital:	2 🗆 ER/O	utpatient 3	DOA Othe	_			er (Specify	<i>'</i> )	
	nerel												
	or: Al	ğ	Y Natural 5   Pending   (Month, Dey Year)   Injury   Work?   2   Accident   investigation   M   1   Yes 2   No										
y Att	lrect n by	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)										
oftai L	erai D		29a. Certifier 1X Certifying Physi	niam. To the beet of	الد - السموطية	a dogsh	and and Altricate	- 484					
Hos	24 hc	edicai	(Check only one)	cian: To the best of m er: On the basis of exa and manner stated	amination an	nd/or investigati	on, in my op	e, date and place, pinion, death occur	red at the time, o	ause(s) and ma date and place,	inner as sta and due to	the cause(s)	
To the H	Vithin Fo the	_	29b. Signature and tittle of certifier	1 111	· -	T 4	29c. License	number		29d. Date signe	d (Month, L	Day, Year)	-
) [			Media	Ull-	mo		DE	35284		1/27	104		
			30. Nam and address of reson who con		(Item 23e)	(Type Print)					1 1	2 - 2 - 2	
t Exc			AMORBA ALLE		219	15.6	vash	ington	STE	aston	smi	21601	
	State Registra	G .	31. Date filed (Month, Day, Year)	32. Registrer's	Signature	A		U					

		1	For State Registrar	State	of Marylan		artment of H		Mental Hygi	ene g. No. 20	04	04429		
			1. Decedent's Name (First, Middle,	Last)		-			2. Date of Death Month	n Day	Y <i>e</i> ar	3. Time of Death		
	Physicia /Medic			Wil:	liam H.	Lyles			January	23 20	04	14:15p M		
7	Examin		4a. Fecility Name (If not institution, g	give street and no	umber)		4b. City, Town, o	r Location of Death	י	4c. County	of Death			
			Shady Grove Adve	ntist H	ospital			ckville			ntgo			
10	Funeral Director		5. Social Security Number 6 220-01-1168	.Sex 1⊠M 2□F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 21,	Year) 1915		ace (State or Foreign try) yland		
	<b>D</b>		Usual Residence of Decedent		10- 6	ty, Town or Lo	anting				10	Od. Inside City Limits		
	rylan	_	10a. State 10b. County		10c. Cit	ry, Town or Lo	cation				''	1 ☐ Yes 21 No		
	Ba-f s	cto	Maryland Mont	gomery	Ger	mantow			1/	Og. Citizen of V	What Coun	10.2		
	ith th	Director	10e. Street and Number				10f. Zip Code			-				
	ath w	<u>a</u>	11463 Applegrath					0876		nited S	tate - America			
	er de	Funeral	11. Marital Status	Armed f	cedent Ever in U Forc <i>e</i> s? . 2⊠No	.5.	Was Decedent of H If Yes, specify Cubi	an, Mexican, Puert	o Rican, etc.)		k, White,			
36	', or	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	If Yes, G	Sive		1 □ Yes 21☑ No	Specify:		Specify	B1a	ck		
8	ture ture	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	siness/Inc	lustry		
5	in 72 n n	plet	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of work done DO NOT use retire	d) auring most of wor	rking					
2	r tha	Completed	7	College	(140131)	Bui	lding Su	*				County		
Maryland 21215-0036	othe	Вес	17. Father's Name (First, Middle, La	ast)				18. Mother's Nar	ne (First, Middle, N	faiden Sumam	10)			
<u>lar</u>	Venta Venta rrked ritc e	10 E	Walter Snowden					Mary Ly						
au	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aurnatic event, the Maulical Examitar must be molified at		19a. Informant's Name/Relationshi	p (Type, Print)					ural Route Number,					
≥,	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Gretchen Chase/	Daughte			Applegr	ath Way,	Germanto	wn, Maryland 20876				
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	B □Removal from	n State	cemetery, cre	matory or other pla		/2004					
Ē	tant:		`4 □Donation 5 □Other (Spe	-	Me		litan Crematoriun Inc Alexandria, Virgin 22. Name and Address of Facility							
Baltimore,	Dermit. Pages 1 and 2 Department of Health a Importent: if item 27 li any injury or other tra once.		21. Signature of Juneral Service Li	HUS	we	/ 2	)lin L. M 26401 Rid	olesworth ge Road.	n P. A., Damascus	. Marvl	L Hom Land	<u> 20872                                     </u>		
	<b>3</b>		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause or	t caused the dea n each lin <i>e.</i>	th. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death		
R.	Physician		Immediate Cause (Final disease or condition		te Renal							days		
446	/Medical		resulting in death)  Due to (or as a consequence of):											
ā <sub>4</sub>	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Aspiration Pneumonia  Due to (or as a consequence of):									week		
- 2	ed sit	line												
	xecul and	xan	that initiated events c. Realter of the time initiated events resulting in death) Last Due to (or as a consequence of):											
8760,	cate be executed physician and the burial-transit													
9	ificate g phy as the	Physician/Medical												
Вох	death certific e attending p od for use as	N/	1F FEMALE: 23b. Was decedent pregnant		outcome of pregn		⊒Ectopic pregnanc	·v			te of delive	Day Year		
	that the death certific ed by the attending p detached for use as	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)  9 Unknown								Month I				
P.0.	The law requires that the tte has been signed by th bage 2 should be detache	hys	9 Unknown			lat t - Al		una in Dort I	23e Did tol	bacco use cont	inhute to th	ne cause of death?		
	signed d be det	by	Part II. Other significant condition		death but not re	suiting in the i	ingeriying cause gi	ven in Parti.				ably 4 😾 Unknown		
ord	w requir been si should	ted	Hypertension, D:			-								
of Vital	e law l has b	Completed by							24a. Was a autops perform	Sy	prior to co death?	psy findings available mpletion of cause of		
		Son							1 ☐ Yes	2 <b>2</b> No	1 🗆 Yes	2□ No		
	Physician: The rthis certificate iral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0:	her	ath Check on on					
	s p	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	11	Inpatient 2	ER/Outpatie	nt 3 DOA	4   Indiani	Home 5 Reside			y)		
UC	tending Pł lea h. tor. After th	ti On	1 ⊠Natural 5 ☐ Pending	(M	onth, Day Year)	Injury	Wo	ork? ]Yes 2∐No						
Division of Vital Records,	after death	ica	2 Accident and Number or Rural City of Town State) 28 Place of Injury - At home, farm, street, factory, office determined											
	al or after after I Dire	erti	27. Manner of Death  27. Manner of Death  28a. Date of Injury  28b. Date											
	To the Hospital or Attending within 24 hours after dea h. To the Funeral Dire tor After completely filled in by the fune	edical (	29a. Certifier (Check only one) Certifying	xaminer: On the	the best of my kr a basis of examin anner stated.	nowledge, dea nation and/or i	th occurred at the to nvestigation, in my	ime, date and place opinion, death occ	e, and due to the c curred at the time, d	ause(s) and ma late and place,	anner as s and due to	tated. the cause(s)		
	To the I within 2. To the I complet	Med	≥ 29b, Signature and title of certifier 29c, License number 29d, Date signed (Month,											
)	۵ ∔ ≼ ⊣		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph A B all 1622 of for denick Ruan 5-, te 213 Cartheriburg											
	7		30. Name and address of person	vho completed c	ause of death (Ite	em 23a) (Type	, Print)			1.4				
	J		Joseph 4 Ba	11 162	est es	denic	K RUA	5-ite	213 GA	ithen	burg	MD 20871		
	St Regist	ate	31. Date filed (Month, Day, Year)	32	2. Registrar's Sign	nature	Sante !				U			

			For State	State of	Maryland	•	artment rtificate			and M		2	0.01	01120		
			Registrar  1. Decedent's Name (First, Middle	( ast)		Cei	runcate	OIL	Jean		2. Date of Dea	th.	U U 4	3. Time of Death		
	Physici	an	SIDNEY	, Lasi)	T F.C	POLD					Month	Day	Year	GAM		
-	/Medic		4a. Fecility Name (If not institution	give street and num		OLOUD	4h City 1	Town or	Location of	of Death		4c Cour	out of Death	7.		
	Examin	er	42 Shamrock	Circle			45. Oxy,		tmins				rroll			
	Funeral		5. Social Security Number		7. Age (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Birth		9. Birtho	place (State or Foreign		
	Funeral Director		129-03-7029	152 M 2□ F	93	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day June 7,	1910	New	York		
			Usual Residence of Decedent				· · · · · · · · · · · · · · · · · · ·									
	rylan thow	_	10a. State 10b. County	arroll	10c. City, 7								1	0d. Inside City Limits 1 ☐ Yes 2 No		
	Be-fs	cto		arroll	V	vestiii	inste									
	vith th	Director	10e. Street and Number	0: 1			10f. Zip		7		1	10g. Citizen o		•		
	s 23e	ra	42 Shamrock			140		2115		-1-0 (0	-4. V M-	Unite	ace - Americ	ates		
9	be filed within 72 hours after death with the Maryland Hygiene.  I Hygiene.  d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be troitined at	/ Funeral	11. Marital Status  1 Never Married 2 Married	Armed For	2		was Decedi If Yes, spec 1 ☐ Yes 2		spanic On n, Mexican Specify:		cify Yes or No- Rican, etc.)		lack, White,	etc.		
5-0036	ural',	d by	3 Widowed 4 Divorced	Year or Da	tes:											
ν.	nati	Completed	15. Decedent (Specify onfy highes			16a. Dece (Give	dent's Usua kind of won DO NOT us	l Occupa k done d	ition <i>Juring m</i> osi	t of worki	ng	16b. Kind of	Business/In	dustry		
2121	withir ane. then	m d	Elementary/Secondary (0-12)	College (1-			earch					II S	Gover	nment		
2 2	Hygiv Hygiv Int.	ပို	17. Father's Name (First, Middle,		<u>T</u>	1100	caren				(First, Middle,					
_	2 should be filed within and Mental Hygiene. Is marked other then aumatic evant, the Me	To Be	Herman		Leopold				Mar			Fleis				
	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationsh Harriet Leopol								<i>lRoute Numbe</i> les <b>tmin</b> s			nd 21157		
O .	es 1 a of Hea of Hea if item ir othe		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	e of her place	9)	D	ate	20c. Location	n - City or To	own, State		
Ë	Pages nent of int: If it		1 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Si		nate					1/27	/2004	Freder	ick,Ma	aryland		
ä	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service	Licensee	1						uffer F					
<u>m</u>	8258		Saymon	Well	reon	/   1	621 O	poss	umtow	vn Pi	.ke / Fr	ederio				
			23a. Part1. Error the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death. ich line.	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death		
) i	Physician		Immediate Cause (Final disease or condition	_a. Cc	NGES	TIV	E	HE	PAT	- 1	GILU	RE		MONTHS		
	/Medical Examiner		resulting in death)	Due to (d	or as a consequence CAO SC. 4	nce of):										
	LAGIIIIII		Sequentially list conditions, if any, leading to immediate	b. 17 974	ERO SCA	ERO	TIC.	Cor	anc	ry	HEART	Dist	ASE	YEARS		
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	\$ 50.00	7 43 4 CONSEQUE	100 01).										
	execunand and al-tra	Examiner	that initiated events resulting in death) Last	CDue to (c	or as a consequer	nce of):			<del></del> -							
760,	ate be executed thysician and the burial-transit	call		L a												
89	tifical g phy as th			(36574)												
ŏ	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy		Ectopic pre	gnancy					ate of delive	•		
P.O. Box	Attanding Physician: The law requires that the death certificate be executed redeath. The death or death. Actor: After this certificate has been signed by the attending physician and actor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		int at time of deat		Other (spe					,	Month	Day Year		
ص ِ	that led by deta	y Ph	Part II. Other significant condition	ns contributing to de	ath but not resulting	ng in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use co	ntribute to th	ne cause of death?		
rds	quires n sigr uld be	ed by	MANT	LE CEL	2 Lyr	n Pito	ma	<u> </u>			1 □ Y	1 Yes 2 No 3 Probably 4 Unknown				
000	sw require s been si	Completed	NON INSUL						MEL	41711	24a. Was a	s an 24b. Were autopsy findings available				
8	sician: The law certiticate has b irector, page 2 s	E O		7			1.191.		7 7 7		autops perform	med?	prior to cor death? 1 \(\sum \) Yes	npletion of cause of		
ā	an: rtifica tor, p	a	25. Was case referred to medical						26. Place	of Death	(Check only on	<del>-/</del>		20.10		
>	ysici is ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 In	patient 2 EP	VOutpatier	nt 3□ DO/	A Othe	r: 4 □ Nu	rsing Hor	ne 5 Aeside	ence 6 🗆 O	ther (Specify	1)		
0	ng Ph ter th neral	Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date o		Bb. Time or Injury	28	Bc. Injury Work	at ?	2	8d. Describe ho	ow injury occi	urred			
<u>~</u>	endir sath. or: Af	atle	2 ☐ Accident investig	ation			М		'es 2 □ l	No						
	or Att	Certification:	3 Suicide 6 Could r 4 Homicide determi	ined 286. Place	of Injury - At home g, etc. (Specify)	ə, farm, str	eet, factory,	office		2	28f. Location (St City or Town		nber or Rura	l Route Number,		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certiticate he completely filled in by the funeral director, page		29a. Certifier TS Certifyin (Check only 2 Medical I	g Physician: To the l Examiner: On the ba	best of my knowle	edge, deat	n occurred a	it the time	e, date and	d place, a	and due to the ca	ause(s) and r	nanner as st	ated.		
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and mann	er stated.				number			9d. Date sign				
	⊬≯≓ö		Y) S	from	Pa	mo		D	016	63		1/2	c lad			
1			30. Name and address of person	who completed cause	of death (kem 2:	3a) (Type.	Print)	90	600	USE	ACH INC	-Toal	ROA	2		
,			VINCENT J	. FIOCC	OFR			w	EST	ma	STE	1/2A	1 2	1157		
	Sta		31. Date filed (Month, Day, Year)	who completed cause.	gistra	θ	1	- 0				,	3			
	Registr	ar	JAN	202004	plane	J.	ACC	w								

Name   Privacion   Mary Fare   If core imminion pre street and removed   Mary Land   Mary Early   Mary Land   Mary Early   Mary Land   Mary Early   Mary Land   Mary Early   Mary Land   Mary Land   Mary Early   Mary Land	Month   Day   28, 2004   11:00 A M   And number   28, 2004   11:00 A M   And number   46. Clty, Town, or Location of Death   Frederick   Frederick   Frederick   S. Class of Bird.   S.		•	State of Maryland / Department of Health and  1 - State Registrer Certificate of Death		giene Reg. No. 2001	04431			
Margarret   V. Long   January 28, 2004   11:   As Feeling Name of Control of Death   As County of Death   As Cou	January 28, 2004   11:00 A M						3. Time of Death			
4. Specially have gifter of residency give several and number)  5. Sourch Set Application of Description  5. Sourch Set Application of Description  5. Sourch Set Application of Description  5. Sourch Set Application of Description  6. Sourch Set Application of Description  6. Sourch Set Application of Description  7. Application of Description  7. Application of Description  100. Conf. Town or Location  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description  100. The Description of Description of Description  100. The Description of Descripti	4c. Curry of Death   Frederick   Frederick   Frederick   Frederick   Frederick   Street   S			Margaret V. Long			11:00 A <sup>M</sup>			
Suntrise Assisted Living Of Frederick    Frederick   Frederick   Frederick   Prederick   erty of the property				eath	4c. County of Dea					
Social Security Number   Social Security Num	T. Age (in yrs. last brinday)			Sunrise Assisted Living Of Frederick Frederick						
Director    Description   Desc	10c. City, Town or Location	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	lin. 8. Date of Birt	h 9. Bir y, Year) Co	thplace (State or Foreign puntry)			
To Street and Warry Land   Treederick   Thurmont   Th	Thurmont    Interpretation   Interpretat	10.0		220-05-6362 1LM 22F 81 Yrs.			yland			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	Thurmont    10f. Zp Code   21788	p s	}				10d. Inside City Limits			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	10f. Zig Code   21788   10g. Citizen of What Country? USA   21788   10g. Citizen of What Country? USA   21788   13. Was Decident of Hispanic Origin? (Specify Yes or No-Was, Specify Cubar, Needson, Poeto Rican, etc.)   14. Race - American Indian, Black White, alc.   Specify: White   15. Mail of Decedent's Usaid Occupation (Give Indian) of What Country?   16b. Kind of Business/Industry (Give Indian) of What Country?   16b. Kind of Business/Industry (Give Indian) of What Country?   16b. Kind of Business/Industry (Give Indian) of What Country?   16b. Kind of Business/Industry (Give Indian) of What Country?   16b. Kind of Business/Industry (Give Indian) of What Country?   16b. Kind of Business/Industry (Give Indian) of What Country (Give Indian) of	aryla shov	_				1 ☐ Yes 2 ☐ No			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	as Decedent Ever in U.S. mod Forces? The Agency of the State of Purpose of Pu	Ne M	ecto			10g Citizen of What Co	ountry?			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	Tyes 2 No   1   19   19   19   19   19   19   19	with t	급			-	,			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	Tyes 2   No Specify:   Specify:   Specify:   White   Specify:   White   Specify:   White   Specify:   White   Specify:   White   Specify:   White   Specify:   Specify:   White   Specify:   Specify:   Specify:   White   Specify:   Specify:   Specify:   White   Specify:   Sp	eath	eral		(Specify Yes or No-	- 14. Race - Ame	aricen Indian,			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	16a. Decedent's Usual Occupation (Give kind of work done during most of working life; De Not use related!)   16b. Kind of Business/Industry   16b. Kind of Business	ter d	S.		uerto Rican, etc.)					
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	Content   Cont	J36	by	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	Homemaker   Dwn Home   Homemaker   Dwn Home   Homemaker   Dwn Home   Homemaker   Dwn Home   Homemaker   Dwn Home   Homemaker   Dwn Home   Homemaker   Dwn Home   Homemaker   Dwn Home   D	2 hou	ted		working	16b. Kind of Business	/Industry			
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mother's Name (First, Middle, Maiden Sumane)   18. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. Intermet's Name-Relationship (Type, Pirrit)   19. Mailing Address (Street and Number of Yural Roule Number, City of Town, State 20 Code)   18. State 21 Command of State 20 Code)   18. State 21 Command of State 21 Code (State 21 Code)   18. State 21 Code (State 2	18. Mother's Name (First, Middle, Maiden Sumame)	212 bin 7	ple	Florente (Secondary (0.13) College (1.40r.54)	Working	0 11				
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	Dora Lewis	21 ad with	Son	7th Homemaker	1					
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code)	nd all Hy vent		17. Father's Name (First, Middle, Last)  18. Mother's N	Name (First, Middle,	Maiden Sumame)				
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	Son   13833 Pryor Road Thurmont, MD 21788	Van Suid b Ment Ment Ment Milc e	٦ ا	Dames I I I I I I I I I I I I I I I I I I I						
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	Date   20b. Place of Disposition (Name of contenting) contenting or other place)   Date   20c. Location - City or Town, State	2 sho	1 3				Zip Code)			
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	Blue Ridge Cemetery 2/02/2004 Thurmont, MD  22. Name and Address of Facility Stauffer Funeral Home, PA  104 E. Main St. Thurmont, MD 21788  Institute death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death of Conset and Death of Death of Conset and Death of Deat	and and ealth m 27	8	3,			Tour State			
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	22. Name and Address of Facility Stauffer Funeral Home, PA  104 E. Main St. Thurmont, MD 21788  Approximate Interval Between Onset and Death St. Thurmont, MD 21788  Approximate Interval Between Onset and Death St. Thurmont, MD 21788  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont, MD 21781  Approximate Interval Between Onset and Death St. Thurmont Interval Between Onset And Death St. Thurmont Interval Between Onset And De	Ore of H if Ital		1 El Bunai 2 Cremation 3 Chemoval from State		20c. Location - City of	Town, State			
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	shat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line.    Approximate Interval Between Onset and Death   Part   Pa	Pag ment ment tant: jury		`4 Donation 5 Other (Specify) Blue Ridge Cemetery 2/0	02/2004					
Physician (Medical Examiner)  23a Pff) Enter the disease, on complete death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process of the control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of each fine. The control of the cause of	Approximate is an each line.  Approximate interest.  Approximate interest.  Interval Between Onset and Death  Approximate interest.  Approximate	Sall semit.					e, PA			
Physician (Modical Examiner)  Physic	Due to (or as a consequence of):    Consequence of consequence of	m gossa					Assessimate			
The state of the s	Due to (or as a consequence of):    23d. Date of delivery			23a. Part). Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	diac or respiratory as	rrest,	Interval Between			
The state of the s	Due to (or as a consequence of):    23d. Date of delivery	196		Immediate Cause (Final disease or condition  a. Almheimers Type Dem.	rentra		45			
The state of the s	Due to (or as a consequence of):    23d. Date of delivery			Due to (or as a consequence of):			1100			
The state of the s	Due to (or as a consequence of):    23d. Date of delivery	LXammer	L	Sequentially list conditions, b. PUMONARY FIBEDSIS			413			
To completion of the state of	City birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year	be sit	lne				1110			
To completion of the state of	City birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year	ecut and I-tran	хап	that infliated events c. C. C. C. C. C. C. C. C. C. C. C. C. C.			7:-			
IFFEMALE:   23d.   1   1   1   1   1   1   1   1   1	City birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year	60, be ex	a E							
So the second of the part of t	City birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year	phys s the		d.						
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	Pregnant at time of death   5   Other (specify)	X Certif	/W	23c It vas outcome of oradinancy		23d. Date of de	livery			
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	23e. Did tobacco use contribute to the cause of death?	BC eath	ciar	in the past 12 months?  APpropriat at time of death 5 Other (specify)		Month	Day Year			
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	24a. Was an autopsy findings available prior to completion of cause of death?   1   Yes 2   No   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   No   No   No   No   No   No	O. The d	iysi							
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	24a. Was an autopsy performed?  1	that	y P	Part II. Other significant conditions contributing to death but net resulting in the underlying cause given in Part I.	23e. Did t	d tobacco use contribute to the cause of death?				
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	al: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify)  a. Date of Injury (Month, Day Year)  B. Place of Injury - At home, farm, street, factory, office  B. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	ds wires	D	FAILURE to Inrive	1	Yes 2,725No 3□P	robably 4 Unknown			
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	al: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify)  a. Date of Injury (Month, Day Year)  B. Place of Injury - At home, farm, street, factory, office  B. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	w req been shou	lete	apit disorder		an 24b. Were a	utopsy findings available			
25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    25. Was case referred to medical examiner?  1   Yes 2   Year    1   Yes 2   Year    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6 X   ther (Specify)  1   Yes 2   Year    27. Manner of Death    28a. Date of Injury    28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Location (Street and Number or Rural Route Injury)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  Work?  28d. Describe	26. Place of Death (Check only one)  al: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 ther (Specify)  a. Date of Injury (Month, Day Year)  Place of Injury - At home, farm, street, factory, office  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  1. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  28c. License number 29d. Date signed (Month, Day Year)	Re la he la ge 2 19e 2	m d	(Ca) 4	perfo	rmed? death?				
The state of the s	al: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  1: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  28c. Injury at Work? 1 Yes 2 No  28f. Location (Street and Number or Rural Route Number, City or Town, State)	- (0		25 Was case referred to medical 26 Place of 1			290110			
To see that the stand of the st	ia. Date of Injury (Month, Day Year)  28b. Time of Injury M  1	Vii sicia s cert irrect		examiner? Hospital: Other		The state of the s	ecify)			
Natural   Signat	M 1   Yes 2   No  1e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  1: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)	Phy Praticisman	<b> </b>				,,			
3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 See. Place of Injury - At home, farm, street, factory, office 5 See. Place of Injury - At home, farm, street, factory, office 5 See. Place of Injury - At home, farm, street, factory, office 5 See. Place of Injury - At home, farm, street, factory, office 6 City or Town, State)  286. Location (Street and Number or Rural Route - City or Town, State)  287. Location (Street and Number or Rural Route - City or Town, State)  288. Place of Injury - At home, farm, street, factory, office 6 Delivery of Town, State)  289. Place of Injury - At home, farm, street, factory, office 6 Delivery of Town, State)  289. Place of Injury - At home, farm, street, factory, office 6 Delivery of Town, State)  280. Place of Injury - At home, farm, street, factory, office 8 See. Place of Injury - At home, farm, street, factory, office 8 See. Place of Injury - At home, farm, street, factory, office 8 Delivery of Town, State)  286. Cocation (Street and Number or Rural Route - City or Town, State)  287. Location (Street and Number or Rural Route - City or Town, State)  288. Place of Injury - At home, farm, street, factory, office 8 Delivery of Town, State)  289. Place of Injury - At home, farm, street, factory, office 8 Delivery of Town, State)  289. Place of Injury - At home, farm, street, factory, office 8 Delivery of Town, State)  289. Location (Street and Number or Rural Route - City or Town, State)  289. Location (Street and Number or Rural Route - City or Town, State)	building, etc. (Specify)  City or Town, State)  1: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	lon nding th. : Ate	atio	M 1 Ves 2 No						
To all of the state of the stat	n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	Atte	ific	determined   289, Place of Injury - At Home, farm, street, factory, office	28f. Location (	Street and Number or F wn. State)	lural Route Number,			
29a. Certifier  Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License symbor.  29d. Date sizeed (Month Day Yes	On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29c License number 29d Date sinned (Month, Day Year)	O e e e e e e e e e e e e e e e e e e e	Seri	Training St. (Specify)						
one) and manner stated.	and manner stated.  29c. License number 29d. Date sinned (Month, Day, Year)	ospit hour unera	Sai							
20d Data signed (Month Day Ver	29c. License number 29d. Date signed (Month, Day, Year)	he H in 24 he Fi plete	edi	one) and manner stated.						
29b. Signature and title of certifier		To t To t	Σ	29b. Signature and title of certifier 29c. License number	746	29d. Date signed (Mon	in, vay, rear)			
allen Reilly MD D34747 0130 20	14 1110 034141 0130 2004	1		Willen Keilly MD D34	7/	01 30	2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1.1	I-radai-	L MINTITAL			
					, 0-1,	1-184-416	K, MN 21101			
31. Date filed (Month, Day, Year) 32. Registral's Signature	32. Registre's Signature	Sta Regist	ate	31. Date filed (Month, Day, Year) / 32. Registre's Signature						

			For State Registrar	State of	Maryla	nd / Depa <i>Cer</i>	rtment <i>tificate</i>			d Mer		ene g. No.	2004		
	Physicia /Medic		Decedent's Name (First, Middle, La     John Lyman								Date of Death Month 01	Day 17	2004	3. Time of Death 1:52 a	
	Examin		4a. Facility Name (If not institution, gives	d Hospit	al		C1ir	nton				Prir	ounty of Death	rges	
	Funeral Director			Sex 7 1⊠M 2□F	'. Age (In yrs	. last birthday) 55 Yrs.	If Under 1		Hours	Min. 08	Date of Birth (Month, Day, 3-02-19	Year) 48	9. Birthp Cour Ten	place (State or Foreintry) nesse	
deeth with the Maryland	a-f ehow	ctor	10a. State 10b. County MD Prince	Georges		ity, Town or Lo inton	cation						1	10d. Inside City Lim 12 Yes 2 ☐ I	
th with th	23a or 24	Funeral Director	10e. Street and Number 784 Sarakal Rd.				10f. Zip (				10	g. Citize USA	n of What Cour	ntry?	
ē	Examinational be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	ces? 2[X]No	-11	Vas Decede Yes, specif		spanic Origin n, Mexican, P Specify:	? (Specify uerto Rica	Yes or No- in, etc.)		Race - Americ Black, White, pecify: B1a	etc.	
altimore, Maryland 21215-0036	iene. than "natur he Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0·12) 11th	ducation ade completed) College (1-4	4or 5+)		ent's Usual kind of work OO NOT use	done d retired)	tion uring most of	working	1		of Business/Ind	dustry	
should be fited	Flants 2 marked by the state of	To Be C	17. Father's Name (First, Middle, Last John W. Lyman Sr						Mary	Hami		aiden Su	mame)		
Mar	Health and tem 27 is mother traum	1	19a. Informant's Name/Relationship ( Mai Pointer-Green								on, MD 20735				
more,	Department of Her Important: If Item eny injury or othe		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Lyman Ridge Cemetery 1/26/2004									20c. Location - City or Town, State Columbia, Tennes			
Balti	Department of Important: If I months or on one on one of the one o		21. Signature of Funeral Service Licer			22.	Name and	Address	s of Facility	Ј.В.		s Fu	neral H	Iome	
8760, ate be executed III	hysician and //Medical xaminer	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	r as a consec	quence of):	Po		nitis		•			Approximate Interval Between Onset and Death Almo was Interval and Int	
O. Box 6	by the attending parached for use as	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   12   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   4   Pregnant at time of death 5   Other (specify)   1   Yes 2   Yes 2   No 9   Unknown   1   Yes 3   Yes 4   Yes 3   Yes 4									23d	Date of delive	ny Day Year	
rds, P.	been signed by should be detac	by	Part II. Other significant conditions of	ther significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cau			
Vital Record sician: The law require	certificate has beerector, page 2 sho	Completed	25. Was case referred to medical exampler?  1 Stress 2 No									as an 24b. Were autopsy findings a prior to completion of ca death?			
f Vit	iis certif directo	To Be										ath (Check only one)  Iome 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify)			
ion of	death. ctor: After thi / the tuneral		E C Modidanii	investigation M 1 Yes 2 No								,			
5 5	Dire	Certification:													
] the Hospital	within 24 hours To the Funeral completely tilled	Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar  29b. Signature and title of certifier	niner: On the bas and manne	is of examina	owledge, death ation and/or invi	estigation, ir	the time n my opi License	nion, death o	ace, and o ccurred at	the time, date	and pla	ce, and due to	the cause(s)	
P	8 48		· Aryon	Uni									gned (Month, E		
2 (	5)	3	BOI Malia	completed cause	of death (Iter	3-4	rint)	3,/1	en Spa	Pina	MO	2	7,3		

			1 - For Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of L		nd Mental F	lygien Reg. N	20		1443
			1. Decedent's Name (First, Middle, Last)	)				2. Date of	Death			3. Time of Death
	Physici /Medio		DARRELL LONG.	JR.				JANUA			ear 4	11:55A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of			c. County of		
			SOUTHERN MARYLAND			CLIN				PRINCE	GEO.	RGES
8	Funeral		5. Social Security Number 6. Security Number NONE	k   7. Ag ]M 2 ☐ F	e (In yrs. last birthday Yrs.	Months Days	If Under 24 Hours	Min. (Month,	Day, Year	7	Country	,
	Director		Usual Residence of Decedent			<u> </u>	11	6 JAN.	17, 2	2004   1	MARY!	LAND
	laryland ahow ed at		10a. State 10b. County		10c. City, Town or L	ocation					10d	I. Inside City Limits
	e-f al	cto	MARYLAND PRINCE GE	ORGES	OXON HILI							XM□Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wha	at Country	13
	ath w		5128 DEALE DRIVE #			20745			UNI	CED ST	ATES	
	er de	Funeral		12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origi n, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Black, V	American White, etc	
36	within 72 hours after death with the Maryland ene. than "natural", or itame 23e or 28e-f ahow fra Madical Exertirer must be notified at	by F	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes √2√7 I If Yes, Give 1 Year or Dates:	No	1 ☐ Yes 2 <b>X</b> XNo	Specify:			Specify:	BLAC	K
21215-0036	2 hou	ed	15. Decedent's Edu	cation		edent's Usual Occupa			16b. l	Kind of Busin		
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	e kind of work done of DO NOT use retired,	<i>during</i> most o )	of working				,
21	filed wit Hygiene ther the	TO.	0									
D	be filed ital Hygi of other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Midd	dle, Maidei	n Sumame)		
<u>X</u> a	should be filed within and Mental Hygiene. I marked other than umatic event, Ine M.	P	DARRELL LONG, SR.					LLE WALDE				
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Ty			ing Address (Street a						ode)
	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itame 23a or 28e-f aho other traumatic event, Ira Medical Exergirer must be notified at		DANIELLE WALDEN / : 20a. Method of Disposition	MOTHER	5128 20b. Place of Disp	DEALE DRI	VE #10	O1 OXON	-	MD 20 ocation - Cit		State
nor	Pages nent of I ant: If its ury or o		1 ☐ Burial ※ Cremation 3 ☐ P	lemoval from State	cemetery, cre	ematory or other place	1					
Baltimore,	그는 근 글	1	* 4 □ Donation 5 □ Other (Specify)  21. Sign turn of Fundral Services License	90 0	2	ITAN CREMA 2. Name and Addres	s of Facility					A, VA
Ba	permi Depa Impo any it			. D O V	M/	RSHALL'S	FUNERA					•
	p.		23a. Part1. Enter the disease, or compliant shock or heart failure. List only or	ications that caused	the death. Do not en	308 SUTTLA ster the mode of dying		AD SULT ardiac or respiratory	LAND, arrest,	_MD 20	A	pproximate
	Physician		Immediate Scuse (Finaf disease or condition	ie cause on each iii	5 50 1		201	· hil			Ö	iterval Between inset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	MMG	Lock A.	11.4			-	
	Examiner		Sequentially list conditions,		cardi	20	CNI	121	1			
14,000	D is	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of).				7			
	and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as	a consequence of):							
8760,	sate be executed bhysicien and the burial-transit	alE		500 10 (0) 23	a consequence on,							
687	tificate ng phys as the	edicai		l						-		
Box	attending p for use as	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						23d. Date of	f delivery	
ă	death certific e attending p id for use as	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		□Ectopic pregnancy □ Other (specify)				Month	Da	ay Year
P.O.	t the by the tache	hys	9 Unknown	9□ Unknown								
S, F	The law requires that the death cer tite has been signed by the attendir bage 2 should be detached for use	by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	underlying cause give	n in Part I.	23e. Di	d tobacco	use contribut	te to the	cause of death?
ord	w requir been si should I	ted						_ 10	Yes 2	12 No 3 □	] Probabl	y 4 ∐Unknown
Record	e law r has be	Completed						24a. Wi	as an topsy	24b. Were	e autopsy	findings available
	The cate h	Con							rformed?		h? Yes 2[	letion of cause of
Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	lognital:		0.1		Death Check on	опе		-	_
	Physicien: this certific	2	1 Yes 2 No	lospital:			4 🗀 Nurs	ing Home 5 Re			Specity)	
L <sub>O</sub>	ding I h. After funer	tlon	1 Natural 5 Pending	28a. Date of Injui (Month, Day	Year) 28b. Time o	Work	at ? ′es 2∐No	28d. Describ	e now infu	ry occurred		
Division of	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, farm, st		03 2		(Street au	nd Number o	r Rural R	oute Number,
<u>≥</u>	afor A after Direct	Certification:	4 Homicide	building, etc	c. (Specify)	i and i and i and i			own, State		, , , , , , , , , , , , , , , , , , , ,	obie riemoor,
	Hospitel	alc	29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge, dea	th occurred at the time	e, date and p	place, and due to the	e cause(s	) and manne	r as state	nd.
	To the Hospitel or Attending Physicien: The lawithin 24 bours after death.  On the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or mpletely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examir one)	and manner sta	examination and/or in	ivestigation, in my op	inion, death	occurred at the tim	e, date an	d place, and	due to the	e cause(s)
	To the within 2 To the c mplet	Σ	29b. Signature and title of certifier	-0 11	1 -	29c. License	number	100	29d. Da	te signed (M	ionth, Day	y, Year)
70		L	Tall	211	400	· D003	324	8	Jai	1 2	1, 2	1004
K			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type	Print)	12.3	00:		n-ii	0	202
			31. Date filed (Month, Day, Year)	32 Registre	ar's Signature	rratis	KU	COM	47-1	U		773
	Sta Registr		JAN 3 0 7004	) hogistic	A	dis.						

State of Maryland / Department of Health and Mental Hygiene

Physician			Certificate of Death		eg. No.	d lilli.
	Decedent's Name (First, Middle, La     MARVIN	st) ROBERT	LEONARD	2. Date of Dea Month JANUARY	Dey Yeer	3. Time of Deat
° /Medical	4e Facility Name (If not institution, giv			or Location of Deeth	19, 2004 4c. County of Dee	
Examiner	1507 Carolina				100	
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yr	Lard s. last birthday) If Under 1 Year If Under 24 H	s. 8 Date of Birth	P.G.	thplace (State or Fore
Director	577-56-2602  Usuel Residence of Decedent	<b>X</b> M 2□ F	61 Yrs. Months Days Hours Mi	ri. (Month, Day Feb. 7,	reer) Co	sh.,DC
ene. than "natural, or items 23s or 28s-f show the Medical Examiner must be notified at empleted by Funeral Director	10a. Stete 10b. County	10c. (	City, Town or Location			10d. Inside City Lin
23s or 28s-f show wat be notfried at rai Director	Md. P.G.		Largo			1)∑ Yes 2□
be notined Director	10e. Street end Number	Y 71 100	10f. Zip Code	1	0g. Citizen of What Co	ountry?
23a c	1507 Carolina	Court	20774		United	Statos
r tems 23 niner_must Funeral	11. Marital Status	12. Was Decedent Ever in		Specify Yes or No-	14. Race - Ame	rican Indian,
by Ex.	1 ☐ Never Married 2 ☐XMarried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 09/2 1 XYes 2 No if Yes, Give Year or Dates: 03/2	1 ☐ Yes 2 ☑ No Specify:	ono ricari, etc.)	Black, Whit	-
ygiene. Per than "natur. It. The Medical. Completed	15. Decedent's Ed (Specify only highest gre	lucation	16e. Decedent's Usual Occupation	ndkina	16b. Kind of Business/	
than " than " he Mer	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)			
		2	Correctional Offi		Dept. of	Correct
I to be	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, I	Maiden Sumame)	
동물을 다	Frances A. Leor	nard	Willi	e Lee D:	xon	
end %	19a. Informant's Name/Reletionship (		19b. Mailing Address (Street and Number or F 1507 Carolina Cou	Rurel Route Number	City or Town, State, 2	Zip Code)
n 27 ner tr	Thelma Leonard	d/wife	Largo, Md. 20774 Plece of Disposition (Name of	I C		
or off	20a. Method of Disposition 1   Burial 2 □ Cremetion 3 □		Plece of Disposition (Name of cemetery, crematory or other plece)	Date	20c. Location - City or	Town, State
nant of ant: if Ite ury or o	4 □ Donation 5 □ Other (Specify		. Veterans Cem.	1/27/04	Chelter	nham. Mc
Depertment mportant: any Injury o	21. Signature of Funeral Service Licen		22. Name and Address of Facility	lodges &	Edwards	F.H.
Depertr Importa any Inji	Jamino, C	diopedas	3910 Silver Hil	1 Rd. S	uitland N	4d 20746
	23a. Pant. Enter the diseese, or com-	olications that caused the dea	ath. Do not enter the mode of dying, such as cardi	ac or respiratory arre	est.	Approximate
ysician	snock, or neart failure. List only	one cause on each line.				Interval Between Onset and Death
Medical	Immediate Cause (Final disease or condition	CARDTAG AD	Dram			
aminer	resulting in death)	a CARDIAC AR	KEST (or as a consequence of):		1	
je je			HEART FAILURE		1	
in and ial-transit	Sequentially list conditions	Ų. — — — — — — — — — — — — — — — — — — —	(or as a consequence of):			
an an an an an an an an an an an an an a	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	DIABETES				
attending physician and for use es the burial-transit clary Medical Examir	that initieted events resulting in death) Last	C	or as a consequence of):			
Med Med	resulting in death) cast					
r use		d				
igned by the attend be datached for us by Physician/	Part II. Other significant conditions or	ontributing to death but not re	sulting in the underlying cause given in Part I.	23b. Did to	becco use contribute	to the cause of de
by the						obably 4X Unkr
o da	MORBID OBESITY					
been signed by the atte should be datached for leted by Physicia	IRMEDMENTATON			24a. Was ar	autopsy 24b. V	Vere autopsy findin vailable prior to
cate has been s pege 2 should Completed	HYPERTENSION			perioni	c	completion of cause of death?
ege 2				1 □ Ye	s 2 🛣 No 1	□Yes 2X No
ertifica ector, p	25. Was case referred to medical		26 Place of De	eath (Check only one		2703 242110
his cer Il direc	examiner? 1 <b>⊠</b> Yes 2 No	Hospital: 1   Inpatient 2	- Other		nce 6 Other (Spec	ifu)
arthi n: 7	27. Menner of Death	28e. Date of injury (Month, Dey Year)	28b. Time of 28c. Injury at	28d. Describe ho		
atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey real)	Injury Work?  M 1 Yes 2 No			
by th	3 ☐ Suicide 6 ☐ Could not be determined	286. Piece of Injury - At r	nome, farm, street, factory, office		eet and Number or Ru	ral Route Number,
rs arer dearn. al Director: After the din by the funera Certification:		building, etc. (Spec	'''	City or Town,	Siate)	
Within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, pege.  Medical Certification: To Be Com	29a. Certifier (Check only one) 1 XCertifying Phy 2 Medical Exam	rsiclan: To the best of my kniner: On the basis of examinent and manner stated.	owledge, death occurred at the time, date and placetion and/or investigation, in my opinion, death occ	e, end due to the ca urred at the time, da	use(s) end manner as te and place, and due	stated. to the cause(s)
Manual Ma	29b. Signature end title of certifier		29c. License number	29	d. Date signed (Month	, Day, Year)
E.O.O	Mattices A	Ullaial1	U.D DC 13140		ANUARY 27,	
¥ 6 9		1/3////////////////////////////////////		JA	MOUNT 4/	4004
	20 Nemo and distriction 10	o o juliju	- Ocal (Time Brief)			
0	30. Name and address of person who c	t /	m 23e) (Type, Print)  MEDICAL CENTER, 50 IRVI			

DHMH 16 Rev 6/95

-44		For State Registrar	-	Ce	rtificate of	Death	1	Reg. No. 20	]4 (	14435
ysici	an	Decedent's Name (First, Middle, La					2. Date of De	<sup>Day</sup> , 200		Time of Death 5:55 PM
Medic		Eleazer Lor  4a. Facility Name (If not institution, giv		-	4h City Town	or Location of Deat	Jan.	4c. County o		7. 33 1
camin	er	Southern Maryland		ter	Clin			Prince		ges
neral		5, Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days			rth av. Year)	9. Birthplace	(State or Foreign
ctor		250-86-7042	(XM 2□F 55	Yrs.	Monais Days	TIOUIS IVIIII		4, 1948	South	Carolina
4		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. I	nside City Limits
NA S	ō	MD Prince (	Georges C1	inton					1	I∐Yes 2X∏No
event, the Medical Exeminet must be notified at	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	Funeral Director	7715 Mike Shapiro	Drive		20735			U. S. A	١.	
	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No to Rican, etc.)	o- 14. Race Black	<ul> <li>American Ir</li> <li>White, etc.</li> </ul>	ndian,
	by F	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  XXYes 2 No If Yes, Give 5/29 Year or Dates: 5/28	/68-	1 □ Yes XXNo	Specify:		Specify:	B1ac1	k
	ted	15. Decedent's E	ducation	16a Dece	dent's Usual Occu	pation		16b. Kind of Bus		
	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	rking			
	Completed		2	Pres	sman			U. S. Go		ent
	Be	17. Father's Name (First, Middle, Last,				Julie I		e, Maiden Sumame	)	
	2	Arthur Loney  19a. Informant's Name/Relationship (	Tuno Print)	10b Maili	na Address (Stree			per, City or Town, S	tata Zin Coa	(a)
	1	Alicia M. Loney -				apiro Dri			2073	per "
	1	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other pla	1	Date	20c. Location - C	ity or Town,	State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specif	Theilioval Ilolli State	eltenh	am Vet.	Cem   1/28	3/2004	Chelten1	nam, M	D
once.		21. Signature of Funeral Service Licer		2:	2. Name and Addr	ess of Facility Be	11 Fune	ral Home,	P. A.	
ā		JUDINA K	WIN81	6	503 01d 1	Branch Av	e., Tem	ple Hills		20748
		23a. Part . Enter the disease, or consultation . List only	plications that caused the dea one cause on each line.	th. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory a	arrest,	inte	proximate erval Between
al	a a	Immediate Cause (Final disease or condition	a AcuteMu	OCKYO	tial Ir	farction	ממ			set and Death
		resulting in death)	Due to (or as a confed	quence of):				1		. 6
	5	Sequentially list conditions, if any leading to immediate	b. Acuto lo Due to (or as a consec		GOZIVO	ntestina)	Dleed	1	10	11
Ī	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,							
		resulting in death) Last	Due to (or as a consec	quence of):						
	icai		_ d.							
	Physician/Med	IF FEMALE:								
	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	aldeath 3[	Ectopic pregnand	;у		23d. Date Mont	of delivery h Day	Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	meath 5L	Other (specify) _					
	'Ph	Part II. Other significent conditions of	contributing to death but not re-	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco use contrib	oute to the ca	use of death?
	d by	Apertension	1				10	Yes 2□No 3	□ Probably	4 Unknown
	ojet	Diabeter 1	Mellitus				24a. Was	an 24b. W	ere autopsy f	indings available
page a stource	Completed						auto perfo	ormed?   de	ath?	
	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only			
	္	1 ☐ Yes 2 ☑ No		ER/Outpatier	IL 3 DOA			idence 6 Other		
	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ıryat ork? ]Yes 2∐No	28d. Describe	how injury occurre	<b>d</b>	
	Certification;	2 Accident investigatio 3 Suicide 6 Could not b	e See Blace of Injury - At h	ome farm str		162 5 140	28f. Location (	Street and Number	or Rural Ros	ute Number.
	ertil	4 Homicide determined	building, etc. (Speci	(y)	oot, ractory, critica		City or To	wn, State)	077101017101	10,140,1001,
			nysician: To the best of my kn							
completely tilled in by	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my	opinion, death occi	urred at the time,	date and place, ar	d due to the	cause(s)
	Σ	29b. Signature and fille of certifier	18 1		29c. Licen	se number		29d. Date signed	(Month, Day,	Year)
1		Tillary Mi	structor		D32	0081		1-23-	04	
	11 1	30. Name and addr as of erson who	completed cause of death (Ite	т 23а) (Туре,		5				
1		Wilmed XI Val	shintation 1	17011	I A MART	on Rd H	OK HIL	1 ch - at.	TEN	2571111

			For State Registrar	State of Maryland / Do	epartment of Certificate of			iene 2004	04436
	Physici		1. Decedent's Name (First, Middle, Last)  Arne John Maki	1			2. Date of Death Wonth January	Day_ Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give 12785 Ridgely Rd	street and number)	4b. City, Town, Greens	or Location of Death	4	4c. County of Death Carolin	
i de	Funeral Director		051-16-6023		Months Day:		8. Date of Birth (Month, Day, Jan 2, 1	9. Birth Cou 920 New	place (State or Foreign ntry) York
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Caroli:	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2X No
	3a or 28a	i Director	Maryland Caroli: 10e. Street and Number 12785 Ridgely Rd	ne Gleensb	10f. Zip Code 216		10	Og. Citizen of What Cou	ntry?
980	d within 72 hours after death with the Maryland jiene. I then "natural", or Items 23a or 28a-f show The Medical Executational be notified at	by Funerai		12. Was Decedent Ever in U.S. Amed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
1215-0	within 72 horene. ene. then "natural to the Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. D completed) ( College (1-4or 5+)	Decedent's Usual Occi Give kind of work don life. DO NOT use retir	e during most of work red)	king	16b. Kind of Business/In	
Maryland 21215-0036	be filed tal Hyg d other event,	To Be Co	12 17. Father's Name (First, Middle, Last) John F. Maki	Chi	ef Enginee		e (First, Middle, N	Merchant M Maiden Surname)	arme
	s 1 and 2 should Health and Men item 27 le marke other treumatic		19a. Informant's Name/Relationship (Ty Valma Maki		Mailing Address (Stree 85 Ridgely		ra <i>l Route Number,</i> Greensbor	City or Town, State, Zip	
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cemetery,	Disposition (Name of crematory or other place)  oro Cemete	lace)		20c. Location - City or T Greensboro ,	
Baiti	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens		22. Name and Add Fleegle a	ress of Facility	bein Fune	eral Home P	A
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to for as a consequence of	Cardio	ALI	or respiratory arre	TON	Approximate Interval Between Osset and Defits
68760,	eath certificate be executed attending physicien and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of  Due to (or as a consequence of					
О. Вох	the thed	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of deliv Month	ery Day Year
<u>α</u>	quires that the signed by ald be detacted	þ	Par II, Dther significant conditions con	nthbuting to death but not resulting in t	the underlying cause g	given in Part I.		acco use contribute to t s 2 □ No 3 □ Prof	he cause of death?
Vital Records,		e Completed	AVERTED  25. ras s referred to medical	Sete NO121			24a. Was an autopsy perform	prior to co death? No 1 Yes	ppsy findings available impletion of cause of 2 No
n of	ng Phys fter this neral dii	To B	avaminar?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir Inj	me of 28c. Injury W	ther: 4 🗆 Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Specia	y)
Divisi	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	Э	28f. Location (Str. City or Town,	reet a <i>nd Number or Run</i> , State)	al Route Number,
	he Hospit in 24 hour he Funere pletely fille	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exemi	sician: To the best of my knowledge, ner: On the basis of examination and/ and manner stated.	or investigation, in my	opinion, death occur	red at the time, da	ite and place, and due t	o the cause(s)
	Tell with Tell com	Σ	29b. martu ngyn certifier	en mo	29c. Licer	4664	29 V	Tan 28	4
			Christian E VE	ompleted cause of death (Item 23a) (T		Ton MD	21629	,	
	Sta Regist		JAN 3 0 2004	32. Registrar s Signature	000				

			1 - For State Registrar	State of Ma	•	partment of H			jiene eg. No 20	04	044	37
	Physici /Medic	al		Creary		u. Ct. Tana	d Paris	2. Date of Deal Month January	22 20		3. Time of E	Death M
	Examin  Funeral  Director	er	4a. Fecility Name (If not institution, give  Dorchester General  5. Social Security Number  221-58-7348	l Hospital	(In yrs. last birthda	Cambridg	e If Under 24 Hrs Hours Min.	. 8. Date of Birth	Dorch	ester		Foreign
T		ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Dorcheste:		10c. City, Town or				,,,,,,		d. Inside City	
ath with the	23a or 28 ust be no	rai Directo	10e, Street and Number 500 Glenburn Ave			10f. Zip Code 21613		1	0g. Citizen of W	Α.		
<b>5-0036</b> 72 hours after dea	ral', or items Examiner in	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (S n, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - Americar k, White, et Whit	tc.	
d 21215-0036 flied within 72 hours after death with the Maryland	and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic evani, II e Madical Examiner mai be nulified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Gi	cedent's Usual Occupi ve kind of work done of DO NOT use retired	during most of wor	rking	16b. Kind of Bu	siness/Indu	stry	
	d Mental Hyg narked othe natic evant,	To Be C	17. Father's Name (First, Middle, Last) David Ralph McCre.		10h Ma	III - Add - (Canada	Mary Vi	me (First, Middle, I	harpnac	e) k		
ore, N	of Health itam 27 rother tr		Daniel McCreary  20a. Method of Disposition	brother	PO	iling Address (Street and Box 564 position (Name of temporary or other places)	Greensbo	ro, Mary		1639		
Baltimore, permit. Pages 1 ar	Department of Important: ff any injury or once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Juneral Service Licens		Greensb	oro Cemete 22. Name and Addres Fleegle an	ry 01/2 as of Facility d Helfen	bein Fune	eral Hor	me PA		ıd
	ysician		23a. Part 1. Enter the disease, or compleshook, or heart failure. List only of immediate Cause (Final disease or condition	ications that caused ne cause on each line	the death. Do not e	N	Greens g, such as cardiac MML	boro, Maj	ryland est,	Ir C	Approximate nterval Betwo Onset and De	een eath
Ex	Medical aminer	ner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	). 	consequence of):							
. Box 68760, death certificate be executed	hysiclan and the burial-transit	ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
O. Box 61 he death certific	by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3	B Ectopic pregnancy Country (specify)			23d. Date Mor	e of delivery oth Da	/ Pay Ye	ar
rds, P.O	gned e de	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cause give	en in Part I.		pacco use contri		cause of dea	
The law re	nis certificate has been sli I director, page 2 should t	Completed			-			24a. Was an autops perform	y p	Vere autops rior to comp eath?	y findings avoidetion of cau	/ailable use of
Division of Vital Records, P.O I or Attanding Physician: The law requires that the	fter t	on: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No ☐ F  27. Manner of Death  1 ☐ Natural 5 ☐ Pending	lospital: Impatier 28a. Tate of Injun Month, Day		of 28c. Injury Work	er: 4 ☐ Nursing H	ath (Check only only only only only only only only	nce 6 Othe			
DIVISIO al or Attandi	within 24 hours after death.  To tha Funaral Diractor: A completely filled in by the fu	Certification:	☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, : (Specify)	M 1 □ \ street, factory, office	/es 2 □ No	28f. Location (Sti City or Town		or or Rural F	Route Numbe	er,
To tha Hospital	in 24 hour tha Funars ipletely fille	Medical C	(Check only 2 Medical Exami	sician: To the best o ner: On the basis of and manner stat	examination and/or	ath occurred at the tim investigation, in my op	oinion, death occu	irred at the time, da	ate and place, a	ind due to th	ne cause(s)	
To	To	M	29b. Signature and title of certifier	MO			17924		9d. Date signed	04	y, Year)	
			30. Name and address of person wholes  NOMAN THANNY  31. Date filed (Month, Day, Year)			TREET O	AMARIC	OCE M	0216	13		
	Sta Registr		JAN 2 7 2004	A September 1	r's Signature	Mar.						

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otato or Ivial	ylalla	•	ficate of		mornar rry	Reg. No.	) () (4	04438
			1. Decedent's Name (First, Middle, Last)						2. Date of De Month		Year	3. Time of Death
Ŀ	Physici /Medic			ICCREADY					01	15 20	004	11:25 AM
	Examin		4a. Facility Name (If not institution, give s					4b. City, Town, or		,		
			ALICE B. TAWES				f Under 1 Yea	CRISFIE or If Under 24 Hrs			RSET	
	Funeral Director		5. Social Security Number  231-02-3754  Usual Residence of Decedent		81		Months Day		8. Date of Bin (Month, Da	y, Year)		ace (State or Foreign fry) GINIA
	land ow		10a. State 10b. County	1	0c. City, T	Town or Local	ion				10	Od. Inside City Limits
	Mary 9-f sh	ţō	MARYLAND SOMERSE	ET	CR:	ISFIEL	D					1 ☐ Yes 2 ☑ No
	or 28¢	je	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Count	ry?
	th wil	aic	201 HALL HIGHWA	Υ			218				S.A.	
Maryland 21215-0020	be filed within 72 hours after death with the Maryland tial Hygiene. od other than "netural", or items 23a or 28e-f show evant, the Medical Examiner must be netitied at	l by Funeral Director	11. Marital Status 1  1 □ Nøver Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	er in U,S.			f Hispanic Origin? (S lban, Mexican, Puert o <i>Specify:</i>	pecify Yes or No o Rican, etc.)	Blac	e-America ck, White, e :: WHIT	etc.
5-0	72 h	etec	15. Decedent's Educ (Specify only highest grade	ation com <i>pleted)</i>	1	16a. Deceden (Give kin	t's Usual Occ d of work don	upation <i>e during</i> most of wor red)	rking	16b. Kind of Bu	usin <i>e</i> ss/Ind	ustry
121	vithin ne. han "	Completed by	Eiementary/Secondary (0-12)	College (1-4or 5+)			OMEMAK			DΩ	MESTI	C
d 2	1 and 2 should be filed withir Heelth and Mental Hygiene. em 27 Is marked other than hther treumatic evant, the M		17. Father's Name (First, Middle, Last)			11	OF ILL IT LIK		ne (First, Middle,			· ·
an	be od o	o Be	ALFRED CLAYTON	PARKS				FMM	A PAYNE			
JZ.	shoul nd Ma mark mark	T <sub>0</sub>	19a. Informant's Name/Relationship (Typ		-	19b. Mailing	Address (Stre	et and Number or Ru		er, City or Town,	State, Zip	Code)
ž	s 1 end 2 should f Heelth and Mer tem 27 Is marke other treumetic		DANNY MCCREADY/SON			16220	MAIN RID	GE ROAD, TA	NGIER, VA	23440		
altimore,	ges 1 el it of Hee If Item; or othe		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ Re		20b. Plac	e of Dispositi etery, cremat	on (Name of ory or other p	lace)	Date	20c. Location -	City or Tov	vn, State
<u>Ĕ</u>	Page nent o ant: If ury or		4 Donation 5 Other (Specify)	emoval from State	NEW 7	TESTAMEN	T CHURCH	1 CEMETERY		TANGIER.		
Balt	permit. Pages 1 Depertment of F Important: If Ite any injury or ot once.		21. Signature of Funeral Service License	Mica	,	25	5046 PA	ARKSLEY RO		KSLEY, V		E 3421
			23a. Part 1. Enter the disease, or complic spock, or heart failure. List only on	ations that caused the cause on each line.	e death. I	Do not enter	he mode of d	ying, such as cardia	or respiratory a	rrest,	1	Approximate Interval Between
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition			ASC						Onset and Death
	Lxammer	<u>_</u>	resulting in death)	Du	e to (or as	s a conseque	nce of):					
	ted nsit	Examiner	<b>_</b> b.				, ,					
<u> </u>	cete be executed physician and s the bunel-transit	Exal	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as	s a consequ <i>e</i>	nce or):				-	
68760,	e be /sicial e buri		triat initiated events	Du	e to (or as	a conseque	nce of);					
68	artificet ing phy e as th	Medicai	resulting in death) Last			,	,				1	
Вох	h cer endin r use		d.									
	e deat he att ied fo	Physician/	Part II. Other significant conditions cont	ributing to death but r	not resultir	ng in the unde	erlying cause (	given in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
Q.	es thet the death ce igned by the attendi be deteched for use		TYPE	II DIA	BFT	ES			10	Yes 2.♥No	3 ☐ Prob	ably 4 ☐ Unknown
of Vital Records,	requir been s should	Completed by						:		an autopsy med?	eve	re autopsy findings illable prior to npletion of cause leath?
Re	he law e has age 2	E C							10	Yes 2√2 No	1 🗆	]Yes 2□ No
ta		BeC	25. Was case referred to medical					26. Place of Dea	ath (Check only o			*
Ξ	Physician: r this certific aral director,	To B	exeminer? 1 ☐ Yes 2 ☒ No	ospital: 1 🗆 Inpatient	2 🗆 ER	VOutpatient	3□ DOA	Other: Nursing H	lome 5 ☐ Resid	dence 6 □Oth	er (Specify	)
ion o	To the Hospital or Attanding Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Y	'ear) 28	Bb. Time of Injury	28c. In W	jury at ork? □ Yes 2 □ No	28d. Describe I	how injury occur	red	
Division	il or Attai s efter dex I Diractor d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of tnjury building, etc. (	- At home Specify)	e, farm, street	, factory, offic	е	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
	A Hospita 24 hours A Funera letely fille	edicai (	29a. Certifier 1 Certifying Physic (Check only one)	cien: To the best of ner: On the basis of ex and manner stated	amination	dge, death or and/or inves	ccurred at the tigation, in my	time, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and ma date and place,	inner as ste and due to	eted. the cause(s)
	within To the	Me	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date signe	,	-
			) N V	1 +	5			D 48098	5	1 1	5/04	
			30. Neme and address of person who cor	npleted cause of deat	th (Item 23	3a) (Type, Pri	nt)					
			Vijay Karumbunatha					_ Crisfi	eld, Ma	ryland 2	21817	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 1	32. Registrar's	signatur	K	haeli s					

		•	1 - For State Registrar	State of Maryland	l / Depa <i>Cer</i>	urtment of Health and tificate of Death		iene 2001	04439
	Physici		1. Decedent's Name (First, Middle, Last)	irainia	MI	houro <i>E</i>	2. Date of Death Month	37 04	3. Time of Death
>	/Medio		4a. Facility Name (If not institution, give st 5990 CORDS-tack			4b. City, Town, or Location of De	path	4c. Cougty of Dea	
2	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		Year) 9. Bii	rthplace (State or Foreign ountry)
	aryland	_	Usual Residence of Decedent  10a. State  10b. County		Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🔊 No
	or 28a-f	Funeral Director	10e. Street and Number	SE IN	(ARic	101. Zip Code 21838	10	og. Citizen of What C	
	ema 23a	neral	5996 CornStack	2. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
9600	nours afte ural', or it	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2 No Specify:		Specify:	3lack
1215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itema 23a or 28a-f ahow event, the Madical Exeminer must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupation kind of work done during most of wood of use retired)  HETIYED	working	Board of	Education
and 2	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)  James Rolle	2ys			lame (First, Middle, M		00.000
Maryland	iit. Pages 1 and 2 should be artment of Health and Mental ortant: If Item 27 is marked o injury or other traumatic eve is.	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street and Number or			Zip Code)
altimore, I	Pages 1 and 2 nent of Health int: If item 27 iry or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	metery, cren	sition (Name of natory or other place)	Date 2	Oc. Location - City or	Town, State
Baltim	permit. Page Department o Important: If any injury or once.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		22		Fungial He	TY AKUM mg	Sco, MD
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.		et 39 'Hampdon A's er the mode of dying, such as card			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	ence of):	Cancel			
*	<b>美加州</b>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):				
,09/	ite be executed sysicien and ne burial-transit	il Examiner	Cause (Discase or injury that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):				
89	2 2 2	Medical	d.						
O. Box	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	<ul> <li>c. If yes, outcome of pregnant</li> <li>1 □ Live birth 2 □ Fetal of</li> <li>4 □ Pregnant at time of dea</li> <li>9 □ Unknown</li> </ul>	death 3□	Ectopic pregnancy Other (specify)		23d. Date of de Month	Day Year
s, P.	The law requires thet the de ate has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions cont	ributing to death but not result	ting in the ur	nderlying cause given in Part I.			o the cause of death?
Record	e law requ has been ge 2 should	Completed					24a. Was an autopsy perform	24b. Were a	utopsy findings available completion of cause of
_		Be Cor	25. Was case referred to medical examiner?				1 Yes 2	No 1 □ Yes	s 2 No
ō	hys his	၉	1 ☐ Yes 2 ② No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending		R/Outpatien 28b. Time of Injury	t 3 DOA Other: 4 Nursing 28c. Injury at Work?	28d. Describe how		ecify)
Division	il or Attending P after death. I Director: After t d in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	M 1 □ Yes 2 □ No	28f. Location (Str. City or Town,	eet and Number or R State)	Tural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Ce	(Check only 2 Medical Examin-	er: On the basis of examination	ledge, death	occurred at the time, date and pla restigation, in my opinion, death oc	ace, and due to the cal	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner stated.		29c. License number	29	d. Date signed (Mon. Jcm. 2	th, Day, Year)
			30. Name and address of person who con	npleted cause of death, (Item 2	23а) (Туре,	D 54422	MI	2/25	-/
	Sta Registi	- &	31. Date filed (Month, Day, Year)	32. Regigyar's Signatu	ire H		1 1.5	-1100	1

			1 - For State Registrar	State of Ma	•	epartmen Certificat				Reg. N	200	4 04440
)	Physici /Medi Examii	cal	Decedent's Name (First, Middle, Last)  JAI  4a. Facility Name (If not institution, give s  712 FRANKLIN A	MES EA	ARL	4b. City,	Town, or	JR. Location of Do		20,		11:30A M
	Funeral Director		5. Social Security Number 6. Sex 219-36-0307		(In yrs. last birth			If Under 24 h	drs. R Date of	Rinth	Q Bir	rthplace (State or Foreign ountry) TH CAROLIN
	the Maryland 28a-f show	Director	Usual Residence of Decedent	LL	10c. City, Town WES!	or Location TMINST				10a C	itizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
-0036	4 within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-1 show than Medical Examination until be tradified at	by Funeral	712 FRANKLIN A	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	0	2	1157 lent of Hi lefty Cubar	spanic Origin? n, Mexican, Pu Specify:	? (Specify Yes or uerto Rican, etc.)	U No-	SA  14. Race - Am. Black, Whi  Specify: WH	encan Indian, te, etc. IITE
nd 21215-0036	iled within Hygiene. ther then " nt, I've We	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5-	<del>)</del>	Give kind of wor ife. DO NOT us OWNE	rk done d se retired,	uring most of	Name (First, Midd	TRE	EE REMO	
Maryland	12 should h and Men 7 ie marke rraumatic	<u>م</u>	19a. Informant's Name/Relationship (Ty)	MES EARI oo, <i>Print)</i> DAUGHTE	19b. i	Mailing Address	(Street a		LE Rural Route Nun WESTMI	nber, City		
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iny or other tra		20a. Method of Disposition  1 □ Burial 2 ☒Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of D	Disposition (Nan	ne of ther place	,	Date 1/21/04	20c. L	ocation - City or	Town, State
Balti	permit. Pag Department Important: any injury c		21. signature of Funer II Survice Licuse	90					LETCHES			HOME MD. 21157
	Pnysician /Medical		23a. Part1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	shal	MAUC		^	22h05			Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions. They leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Diverto (or as a	consequence of	þ:						
.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetel death	3 □Ectopic pre 5 □ Other (spe					23d. Date of dei Month	livery Day Year
Δ.	w requires that I been signed by should be deta	by	Part II. Other significent conditions con	tributing to death bu	t not resulting in t	he underlying ca	tuse give	n in Part I.			1/	o the cause of death?
of Vital Records,		Completed								opsy formed?	prior to death?	utopsy findings available completion of cause of
on of Vit	nding Physicien: 1 th. : After this certifical stuneral director, p	ition: To Be	25. Was case referred to medical examiner? 1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1  Inpatien 28a. Date of Injury (Month, Day	t 2 ☐ ER/Outp (28b. Tin (Year)		Bc. Injury Work	r: 4 ☐ Nursing	g Home 5 🔀 Re 28d. Describe	sidence		cify)
Division	itel or Attending rs after death. al Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	(Specify)				City or T	own, State	9)	ural Route Number,
	To the Hospitet or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Phys 1 Medicel Exeminates 29b. Signature and title of certifier	icien: To the best of er: On the basis of a and manner state	examination and/	or investigation,	in my op	nion, death oc	ace, and due to the	e, date an	d place, and due	to the cause(s)
	WIL	-	1 Ramos		u.3 nuo		D3	1660		01	te signed (Monti	204
	Sta	te	30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person address of person and address of person address of pers	SALVINI	1 29	STDA	ier	AVENI	· West	MIN	ster, 1	MARY LAND
	Registi	-	JAN 2 2	32. Registrar	eva Is	board	2		•			

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JÄNUARY 26, 2004 BETTIE EARLENE MILLER 7:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER NURSING/REHAB CENTER WESTMINSTER CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUNE 13, 1937 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F **Director** 215-34-6159 MARYLAND 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "netural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at 1.□Yes 2□No Directo MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 TIMBER RIDGE DRIVE APT. 319 21157 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: δ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER CUP MANUFACTURING it of Health and Mental Hyg If item 27 ie markad othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ပ EARL PLETZER AMANDA WHITCOMB PETERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMANDA JEAN SIPLING/DAUGHTER HANOVER, PA 401 THIRD STREET, 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State h☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. EVERGREEN MEM GARDENS 1/29/2004 FINKSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A.
91 WILLIS STREET, WESMTINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death, po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe Rheumatoid Pnysician 30 4 EAU /Medical Examiner Sequentially list conditions, it and leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events Dira to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 □Unknown been si should l 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy performed 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Division 1/2 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: # 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō To the Hospitel o within 24 hours af To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26/2004 K. Ochuca ig Ms MJL 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD 291 STONER THOMAS K. GALVIN III M.D. 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gleen & Spark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Elmer Lee Martin January 2004 1:00 p /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Nursing & Rehabilitative Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1<del>/</del>2 M 2□ F Director 219-01-5197 84 Yrs Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Ia marked other than "naturel", or Items 23e or 28e-f ehow traumatic event, the Mudical Examinar must be notified at Director Carroll Hampstead 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4208 Maple Grove Road USA 21074 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 □ Widowed 4 □ Divorced "naturel", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Station Agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt iment of Health and Mental Hy tent: If item 27 Ia marked oth jury or other traumatic event Denton O. Martin Mary Susan McLaughlin ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Martin, wife 4208 Maple Grove Road, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery | 01/28/2004 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? rmed? 20 No 1□ Yes 1 ☐ Yes 2 ☐ No : After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 425 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 K No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation To the Hospitel or Anomore, within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral D 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Contrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10.52 Intiny d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 2

32. Registrar's Signature

			riease	Obstact Manda				•	•	
			1 - For State	State of Marylan	-			ientai Hyg	iene	01.1.1.2
			Registrar		Cei	rtificate of	Death		eg. No C U U	04443
	Physici	an	Decedent's Name (First, Middle, Las	t)		1		<ol><li>Date of Deat Month</li></ol>	h Day Year	3. Time of Death
	/Medic		Hlbert	1	Mak	le		01	20 2004	1 10:55 AM
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dee	th
			Larkin Cha			Bowie			Prince G	eurges
1	Funeral		5. Social Security Number 6. Security Number 11	7. Age ( <i>In yrs</i> . XM 2□F 69	•	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 24	Year) 9. Bir	thplace (State or Foreign punity) Yland
	Director			05	Yrs.			July 24	, 1934 Mar	ylanu
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	f sho	5	Maryland Prince G	eorges Br	andywi	ne				1 X Yes 2 □ No
	the 1	Director	10e. Street and Number	.001900		10f. Zip Code		10	og. Citizen of What Co	ountry?
	with a o	ā	15011 Baden Naylor	Poad		20613		"	USA	,
	leath	Funeral	11. Marital Status	12 Was Decedent Ever in II	.S. 13.1		Hispanic Origin? (Spe	city Yes or No-	14. Race - Ame	erican Indian.
	ter d	ᆵ	1 ☐ Never Married 2 [X] Married	Armed Forces? 1 ☐ Yes 2 ☐ No	1		Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Whit	
33	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: Bl	ack
21215-0036	72 hours after death with the Maryland "neturel", or Itams 23e or 28e-f show clical Examinar must be notified at	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	Industry
75	within 7 ene. than "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of workind)		Drilog Tumb	er Company
2	glend arth	5	12		Cai	penter			ryres Luill	er company
b	e file	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	faiden Sumame)	
<u>a</u>	ould be Mental arked o	2	Rome	Makle			Margaret		Fowler	
Maryland	SPEE		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or Rura	il Route Number,	City or Town, State, 2	Zip Code)
Σ	and 2 halth n 27 ar tr		Mildred Makle/Wife	e	15011	Baden Na	aylor Road	d Brandy	wine,Maryl	and 20613
ore.	of Hariten		20a. Method of Disposition		Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce)	Date 2	20c. Location - City or	Town, State
Ĕ	Page nent int: h		MBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Res	urrect	ion Ceme	tery 1/28/	'04 C	linton,Mar	yland
Baltimore,	permit. Pages 1 and 2 Department of Haalth a Important: If item 27 Is any injury or othar trae		21. Signature of Funeral Service Licens	500	22	. Name and Addre	ess of Facility			
Ω	8858	1. A	Coussa Off	MO1	323 Ad	ams Fune:	ral Home E	P.A. Aqua	asco,Maryl	and
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat	h. Do not ent	er the mode of dyi	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Pnysician	00 1	Immediate Cause (Final disease or condition		Lennt	1-6 20	Point 1	1000	00	Onset and Death
7	/Medical		resulting in death)	a. Due to (or as a conseq	uence of):	10	1.	11260	20	- Trucs.
	Examiner		RESERVE LITTLE REPORT OF THE PROPERTY OF	Coronan	4 1	arte	eart I	Secur	c.	Term &
		Je	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uerice of):		, ,			1000
	ite be executed ysician and ne burial-transit	Examin	Cause (Disease or injury that initiated events	c.						
o,	an al		resulting in death) Last	Due to (or as a conseq	uence of):					
1760,	ite be iysici ne bu	ical		d						
68	death certificate I attending physi I for use as the b	Med	IF FEMALE:							
Вох	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	v		23d. Date of del	
	dea death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d		Other (specify)			Month	Day Year
P.O.	by the	hy	9 ☐ Unknown							
	w requires that the death certificate be execul been signed by the attending physician and should be detached for use as the burial-tran	Completed by Physician/Med	Part II. Other significant conditions co	_	-	nderlying cause giv	ven in Part I.		acco use contribute to	
p	aquir en si ould I	pe	- HTMIGUE S.	brillation	۸ ا			1 □ Ye	s 2√No 3 Pr	obably 4 □Unknown
သွ		pie						24a. Was an		stopsy findings available completion of cause of
Division of Vital Records,	The law cate has b page 2 sl	E						perform	ed? death?	2□ No
ital		BeC	25. Was case referred to medical				26. Place of Death			
>	Physician: r this certificatal director,	10 E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA O#	ner: Nursing Hor	ne 5 ☐ Reside	nce 6 □Other (Spe	city)
0	19 Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	ry at	28d. Describe ho	w injury occurred	
.0	ath. r: Af	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation				Yes 2 □No			
<u>Vis</u>	or Attanding after death. Director: After in by the fune	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office	1	28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
ō	rs after all DI	Certification;							, ,	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	cal	29a. Certifier 12 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina	wledge, death	occurred at the timestigation in my	me, date and place, a	and due to the ca	use(s) and manner as	stated.
	the H in 24 the F iplete	Medical	onej	and manner stated.						
<b>.</b>	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	1. ~ 101	NA	29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
			1 Kakes	navalo	101	11	2010	8	1/22	1001
T	1,62		30 Name and address of person who	completed cause of death (Item	n 23a) (Type.	Print)	,			T
9	PU		Kakesh Hror	a m.b. 143	00 Ga	Uant to	x Lane ste	222 B	owie, MD.	20715
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture .	Sports				
	Registr	ar	א זות פ		- 50	The state of the s				

			For State Registrar	State of Maryla		artment of H			giene <sub>Reg. No.</sub> 2004 04441	and dress
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of De	Day Year	
\	/Medic	al	CLARENCE  4e. Facility Name (If not institution, give	W. street and number)	MU	JNDY 4b. City, Town, or	Location of Dea	Januar th	y 18, 2004 11:53 A M	_
	Examin	er	Frederick Memor			Frede	erick		Frederick	
	Funeral Director	4	5. Social Security Number 6. Se 138–18–0454	ส์น วกร	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) Country)	7
	D		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation			10d. Inside City Limits	_
	Maryla f sho	ţō	Maryland Carroll		Mount	Airy			1 ☑ Yes 2 ☐ No	)
	or 28a	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
	ath wi	ral		Blvd.	11.6	21771		Cassifu Van er Ne	United States	
336	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23s or 28s-f show It a Medical Examirat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 因Yes 2 No If Yes, Give Year or Dates:1939		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 17 No	Ispanic Origin? (san, Mexican, Puer Specify:	to Rican, etc.)	Black, White, etc.  Specify: White	
Maryland 21215-0036	n 72 hor "natur	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind of Business/Industry	
212	ed within giene. er than "	omo:	Elementary/Secondary (0·12)	College (1-4or 5+)	Eng	ineer Ass	sociate		Phone Company	
Pu	be file ital Hy d oth	Be	17. Father's Name (First, Middle, Last)					, , ,	Maiden Sumame)	
ryla	should by and Menta rmarked umatic ev	ဥ	Clarence 19a. Informant's Name/Relationship (T)		lundy	ing Address (Street	Elsie		Westervelt er, City or Town, State, Zip Code)	
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		Dorothy E. Mundy /			Merridal			Airy, MD 21771	
Baltimore,	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F		. Place of Disponentery, cre	osition (Name of matory or other place	ca)	Date	20c. Location - City or Town, State	
ţ	permit. Pages 'Department of H Importent: If ite eny injury or of		*4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	Fr		Cremator			Frederick, Maryland	_
Ba	Depa Impo eny i		Raymand C	Peleran					Funeral Homes, P.A. unt Airy, MD 21771	
1000	Physician /Medical Examiner	16	23a. Perf 1. Exter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ne cause on each line.	HERO:				Approximate Interval Between Onset and Death Onset and Death	2
8760,	cate be executed oblysicien and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
.O. Box 68	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	⊒Ectopic pregnancy □ Other <i>(specify)</i>	,		23d. Date of delivery Month Day Year	
ds, P	signed to	b	Part II. Other significant conditions co	IN SUFFIC	-		en in Part I.		obacco use contribute to the cause of death? Yes 2 ∰No 3 ☐ Probably 4 ☐Unknowr	1
Il Records,		Completed				/		24a. Was autor perfo 1 Yes		Э
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		et 3 DOA Oth	0.00	eath (Check only o		
of	Phys	on: To	27. Manner of Death 1 Phatural 5 Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	of 28c. Injur Wor	y at k?	-	dence 6 Other (Specify) how injury occurred	_
Division	ten fleati tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si ecify)		Yes 2 □ No	28f. Location (. City or To	Street and Number or Rural Route Number, wn, State)	
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exem	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at the tirnvestigation, in my o	me, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)	
	To the within 2. To the Complete	Me	29b. Signature and titlerol certifier	7	4 0	29c. Licens	se number	0	29d. Date signed (Month, Day, Year)	
•	1		· //acc	·	m.D.	1	12649	7	1-22-04	
	1		30. Name and address of person who of Ronald E. Miller	ompleted cause of death (I	Dr. /	Mt. Airy,	MD 21	771		
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 6 21	32. Registrar's Sig		( - N -				

			1 - For State Registrar	State of	Marylar		artmen rtificat				lental Hyg	giene Reg. No	200	Professional Profe	04445
	Physici	an	Decedent's Name (First, Middle	le, Last)							2. Date of Dea	ith Da	у Үөс		3. Time of Death
	/Medi		Mary	Catherine		rkoe					January				6:30pm <sup>™</sup>
	Examir	ier	4a. Facility Name (If not institution	_	ber)				Location			4c	. County of De		
			College View 5. Social Security Number		. Age (In yrs.	last hinth days	If Under		ericl		0.0.4			eder	
П	Funeral Director		215-14-1736	1 M 2 M F	94	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month Day Dec 12	Year	9. E 009 Ma	Birthplace Cou <i>ntry)</i> LY LE	e (State or Foreign
	ש		Usual Residence of Decedent								DCC 12		05 116	тутс	and
	rylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d.	Inside City Limits
	Ba-fa	cto	Maryland Frede	rick		Fred	erick	:							1 X Yes 2 □ No
	or 2	Dire	10e. Street and Number				10f. Zip	Code				l0g. Cit	izen of What	Country?	
	s 23e	ral	227 East Four						1701				J.S.A.		
	itam	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deced	ces?	.S. 13.	Was Deced f Yes, spec	lent of Hi city Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Ar Black, WI</li> </ol>		ndian,
980	urs af	by	3 ₩ Widowed 4 Divorced	If Yes Give	es:		1 ☐ Yes	2 <b>∏</b> No	Specify:				Specify: [	√hit	е
Ŏ	within 72 hours after death with the Maryland ene. than "natural", or frams 23a or 28a-f ahow ta Madical Examirer must be notified at	Completed	15. Deceden	t's Education		16a. Deced	ient's Usua	I Occupa	ition			16b. Ki	ind of Busines	s/Industr	ry
2	ithin i	nple	Elementary/Secondary (0-12)	st grade completed)  College (1-4	4or 5+)		kind of wor DO NOT us		uring mosi )	t of worki	ng	ъ.			
7	ygien ygien yar th	So	8			Sales	Cler	CK					tail St	ore	
and T	be fill	Be	17. Father's Name (First, Middle,		70,,,,,,	-1		i			(First, Middle,	Maiden			
ž	hould d Mer marke matic	၉	Pinkney 19a. Informant's Name/Relations		Varrenf			15	Bes		·-		Eat		
Ma	d 2 s th an t7 is r traur		Betty M. McBee								, Frede:				
ō,	Heal Heal tam 2		20a. Method of Disposition	Daugittei	20b. P	lace of Dispos	sition (Nam	ne of			-		cation - City		
<u>o</u> E	ages ant of at: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate Mt	emetery, cren Olivet	natory or of Ceme	her place eterv	Jan		2004				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-f ahow any injury or othar traumatic avant, If a Madical Examiner must be notified at once.		21. Signature of Funeral Service		22 - 24	22	. Name and	d Addres	s of Facility	v .				_	•
m	F T T T		Hellow le	Ropers	M0070	06 10	Keene	ey &	Basf	ord	P.A. Fu Freder	nera	al Home	<u> </u>	21701
Ė			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	used the death	n. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory arr	ECK.	, mary.	App	proximate erval Between
	Physician		Immediate Cause (Final disease or condition	1915, 73, 10	oral Va	occular	· Acci	dont	-						set and Death
	/Medical Examiner		resulting in death)		r as a consequ		ACC	ldem							
	LAditiitiei		Sequentially list conditions,		cioscle		Cardi	iovas	scula	r Di	sease				
	bet isit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence or):									
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):						-		-	
9/8 8/90	the death certificate be executed y the attending physicien and iched for use as the burial-transit	dlcal		d											
9	tificat ig phy as the	edic		- u.											
X Q	leath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pre					2	3d. Date of de	elivery	
ם מ	ed fo	sicie	in the past 12 months? 1 □ Yes 2 XNo		it at time of de		Other (spe						Month	Day	Year
J.	uires that the de signed by the a id be detached f	Physician/Me	9 Unknown								,				
Š,	eng gne	۵	Part II. Other significant condition  Congestive Hea			ılting in the un	derlying ca	use giver	n in Part I.				se contribute t		
cord	ned hou	eted	Congestive nea	irt rariure	:						1 U Ye	s 21,	X[No 3∐ P	robably	4 Unknown
d)	2 8 2	ompleted					-				24a. Was ar autops	/	24b. Were a prior to	utopsy fi complet	indings available ion of cause of
	n: The icate h	O.								_	perfórm 1 Yes 2	ied? <b>⊈</b> iNo	death? 1 ☐ Ye	s 2 🗆	No
Vital	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Othor			(Check only one				
ō .	Physic ruthis oral di	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	i 1 □ lub	atient 2 🗆 E	ER/Outpatient 28b. Time of		`	+V IANI		ne 5 🗆 Reside 8d. Describe ho			ecify)	
0	ding th. : Afte	atlon:	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	Injury	M	c. Injury : Work?	n" es 2.∐N		od. Describe 110	wanjury	occurred		
DIVISION	Attar r dea ector by the	ifica	3 Suicide 6 Could n	ned 288. Place of	Injury - At hor	me, farm, stre	et, factory,				8f. Location (Str	eet and	Number or A	u <i>ral Ro</i> u	ite Number.
5	safte safte al Dir	Certific	4   Homicide	building	, etc. (Specify,	)					City or Town	State)			
	ospit hour unara		29a. Certifier 1 Certifying	hysician To the be	est of my know	vledge, death	occurred a	t the time	, date and	place, a	nd due to the ca	use(s) a	and manner a	s stated.	
	To the Hospital or Attending Physician: within 24 hours after death To the Funaral Director: After this certific completely filled in by the funeral director.	ledical	one)	and manner	stated.					occurre	at the time, da	te and	place, and du	e to the o	cause(s)
-	or with	Σ	29b. Signature and title of certifier					License D319					signed (Mon	-	
		-	1						12		J	anu	ary 23	, 20	IU4 
	10		30. Name and address of person v												
	Stat	e	Julio Menocal, 31. Date filed (Month, Day, Year)		4 Opos istrar's Signati	SUMLOW	n Pik	e, F	reder	ick,	Maryla	nd_	21702		
	Registra	٠		20	Bullian :	H 1	Locale	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ ] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 2004 23 12.35pHENRY MARTIN MERHLE 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**⊠**M 2□F Yrs. 79 DEC.29, 1924 219-14-9188 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Frederick Thurmont 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14809 Sabillasville Rd. 21788 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Insurance 11 Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Henry Martin Mable Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21798 Martin / son 11806 Creagerstown Rd./ Woodsboro, MD Wayne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Frederick Crematory\_ 01/25/2004 Frederick, Maryland ^ 4 □Donetion 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 104 E. Main St./ Thurmont, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARYM GEAL 220 disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of)

23d. Date of delivery

Month

Day

3 ☐ Probably 4 ☐Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Year

Physician /Medical **Examiner** 

> burial-transit and

use as the

ö

director, page 2 should be detached to

this the funeral

After

within 24 hours after death. To the Funeral Director: A

5

the

filled in by

completely

permit. Pages 1 Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28e-f ahow

Directo

Completed by Funeral

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Iteme 23s or 28e-1 show ury or other treumatic event, the Medical Examinet must be motified at

Baltimore, Maryland 21215-0036

Examiner by Physician/Medicai Completed Be Medical Certification: To

Hospitel or Attending Physicien: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confiler

State Registrar Michael

31. Date filed (Month, Day, Year)

110 Baughmans Lane / Frederick, Maryland 21702 Costello 32. Registrar's Signature 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

MDD 41378

		•	For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of H tificate of I	lealth and M Death		iene 20 (	)4 04447
Ē			Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Physicia		Nancy	Mulca	ıhv			Month January	Day Y 200	
	/Medic Examin		4e. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	·	4c. County of	Deeth
	LAUITIII	٠,	Glade Valley Nursi	ing Home		Walker	sville		Freder	cick
	Funeral	-	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year) 9	. Birthplece (State or Foreign Country)
	Director		191-12-4249	M 2⊠F   8	30 Yrs.	INOTALIS Days		Aug. 4,	1923 Pe	ennsylvania
	p .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	aryla ahov	_			Walker					1⊠Yes 2□No
	8e-1	Director	Maryland Frederic	K	walker	10f. Zip Code		1	0g. Citizen of Wha	at Country?
	with t		10e. Street and Number					"		
	a 23	rai	229 Challedon Dr	LVE 12. Was D <i>ec</i> edent E	verinits 13.1	2179		ecify Yes or No-		States American Indian,
	Item Item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ N		Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.
336	hours after death with the Maryland turel; or Itema 23e or 28e-1 ahow at Exportment be rediffed at	by	3 ⅓ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:		Specify:	White
Ŏ,	2 hou		15. Decedent's Educ	cation	16a. Deced	ent's Usual Occup	ation	ina	16b. Kind of Busir	ness/Industry
212	filed within 72 Hygiene. other than "natent, it e Me alca	Completed	(Specify only highest grade	College (1-4or 5-	life. I	DO NOT use retired	during most of work i)	my		
21.	filed withi Hygiene. other than	E	12			ıtive Sec			Departmen	nt Store
פ	0 = 0 >	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
<u>a</u>	ould be Mental mrkad o	10 0	Wayne D. Stizinge	r			Pauline		Available	
Maryland 21215-0036	2 should be and Mental is marked raumatic av		19a. Informant's Name/Relationship (Ty)	pe, Print)			and Number or Run			
	and 2 ealth n 27 i		Nancy J. Fairfax /	Daughter						yland 21793
altimore,	of He of He fitan		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac		ary 24,	20c. Location - Ci	ty or Town, State
Ĕ	Pages nent of ant: If its ury or o		'4 □ Donation 5 □ Other (Specify)	Sinovar nom State	Frederick		ry	2004 F		,Maryland
Balt	permit. Pages 1 and 2 should b Department of Health and Menis Importent: if item 27 is marked any injury or other traumatic a <u>once</u> .		21. Ignature of Theral Service Ligense	*	16	Name and Address	<sup>ss of Facility</sup> Sta imtown Pil	auffer Frede	uneral Ho erick, Ma	omes, P.A. aryland 21702
		$\Box$	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused						Approximate Interval Between
H	Physician		Immediate Cause (Final	Chronic	. Costancti	e fulm	onary (	h COA 20		Onset and Death
	/Medical		disease or condition resulting in death)	l	consequence of):	LL TOCTYTE	CT(N CG)	7(30,100		
1	Examiner			,	. ,					
	¥	Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	d d ansit	Examiner	Cause (Disease or injury that initiated events							
ó	exection and and rial-tr	EX	resulting in death) Last	Due to (or as a	consequence of):					
8760	icate be executed physicien and s the burial-transit	dlcai		1						
9	ntifica ng ph as th	Med	IS SELVALE.							
Вох	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnancy	1		23d. Date of Month	
Э.	o dea	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			World	. Day .ou.
P.O.	that the de led by the a detached	h	9 Unknown				- 1- B 1	22a Did tal	naan una naatrib	ute to the cause of death?
	res tha iigned be de	by	Part II. Other significant conditions cor	ntributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.		_	
ord	w require been si should t	ted	Dementia					1)Z Ye	es 2 □ No 3	Probably 4 Unknown
ecc	as be	ple						24a. Was a autops	y prid	or autopsy findings available or to completion of cause of
m m	sician: The law certificate has b irector, page 2 s	Completed						perform		ath? ]Yes 2⊡ No 
ta	ian: artifica ctor,	Be	25. Was case referred to medical examiner?				26. Place of Dear	h (Check only on	e)	
<u></u>	Physician: r this certifica ral director, I	70	1 Yes 2 No	lospital: 1 ☐ Inpatie			4 Nursing Ho		ence 6 Other	
0	ng Pi	:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o r Yeer) Injury	Wor	rk?	28d. Describe ho	ow injury occurred	
000	Mttendi death. ctor: A y the tu	cati	2 ☐ Accident investigation				Yes 2 □No			
Division of Vital Records,	ter de iract	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At home, farm, sti :. (Specify)	eet, factory, office		281. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
Ω	urs af		language and the second							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	Medical			of my knowledge, deat examination and/or in ted.					
	o the	Me	29b. Signature and title of certifier	1	2	29c. Licens	se number	2	9d. Date signed (	Month, Day, Year)
	- >F 0		CHARMO B	( a a a a	. //	Du	10307		JAN Z	3 04
	:		30. Name and advress of person who co	ompleted caus of di	eath (Item 231) (Type,	Print)	10001	-	. 1.79	
	$\mathcal{Q}$		EUGENE B CASA	AGRANDE	TS640 POS S Signature	SUNTOWN	PixE F	REDERICK	MD 2	1702
	Sta	ate	31. Date filed (Month, Day, Yeer)	32. Registra	s Signature	And H.				
	Regist	rar	JAN 2	0 ZUU4 D	wer it	Liveren				

			For State Registrar	State of Maryla		rtment of H			giene Reg. No. 201	
	Physici	an	1. Decedent's Name (First, Middle, Las	7_ugene	Mark			2. Date of Dea Month	ath Day Ye	3. Time of Death
	/Medic Examin Funeral Director		4a. Fecility Name (If not institution, give	Street and number)	-1-1			8. Date of Birth (Month, Da) May 10	Howar)  4c. County of I  Howar	
36	be itled within 72 hours atter death with the Maryland stal Hygiene. ed other than "natural", or items 23e or 28e-f show event, the Medical Examine treat be notified at	by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Howard  10e. Street and Number  3004 N. Ridge Roa  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced			City 10f. Zip Code 2104	3 lispanic Origin? (Spe an, Mexican, Puerto Specify:		10g. Citizen of Wha United S  14. Race - Black, V Specify:	tates American Indian, While, etc.
d 21215-0036	e filed within 72 hour al Hygiene. other than "natural vent, the Medical E.	Completed	15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ucation	(Give k	ent's Usual Occup ind of work done O NOT use retired enter	durina most of worki		18b. Kind of Busin  Constru  Maiden Sumame)	,
Maryland	should be to not Mental to marked of umatic eve	To Be	Albert Markley  19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailing	Address (Street	Lora Bell	l Freela	and	te, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 Is marks any injury or other traumatic <u>once.</u>		Elwood Wallich/)  20a. Method of Disposition  1 Surial 2 Cremation 3   4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen	Removal from State	b. Place of Dispos cemetery, crem St. Johns 1044 22.	ition (Name of atory or other place S Cemete: Name and Addre	ry 1-28- ss of FacilityHar1	-2004 Cy H. W.	20c. Location - Cit Ellicott itzke's F	
8760,	Physicien and /Medical Examiner she private in the private intensit	dical Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)	eath. Do not ente					Approximate Interval Between Onset and Death
P.O. Box 6	the death certif y the attending iched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 1	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
Records, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the un	derlying cause giv	en in Part I.	1 □ Y	es 2 □ No 3 [	
Vital Rec	The ate h	Be Completed	25. Was case referred to medical examiner?				26. Place of Death		sy prior dear 22 No 1 🗆	
Division of V	or Attending Physiter death. irector: After this n by the funeral di	Certification: To	1 Yes 2 No  27. Manny r of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be det mined	28a. Date of Injury (Month, Day Year	at home, farm, stre	28c. Injun Worl M 1 🗀	y at k? Yes 2 \( \backsquare \) No	28d. Describe h		Specify) or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier (Check only one)  2 Medical Example 19 Medical Example	ysi ann To the best of my ther: On the basis of exam and manner stated.	knowledge, death nination and/or invi	occurred at the tin estigation, in my o	pinion, death occurr	ed at the time, o	cause(s) and manne date and place, and 29d. Date signed (A	due to the cause(s)
	F 3 F 8		30. Name and address of person who	completed cause of death (	Item 23a) (Type F	Print	0000066	20	AN 251	.04
	+5 100 Sta		31. Date filed (Month, Day, Year)	1638 6 N	gnature The	WI and	e# 500.5	Daltimor	e, AD	21208
DH	Registi MH 17 Rev 1/2		JAN 2	8 2004 > Bloc	ORIGIN/	AL.				

	_!						Cei	TITICAT	e or	Deau				lo.		,	
eician	ľ											Reg. No.  2. Date of Death Month Day Year January 29 2004 10:10 A Mand Part Part 10:10 A Mand Part Part Part Part Part Part Part Part					
		Harolo	a Ea	ward McD	onou	ign						Janua				10:	:10 A
Thysician  Medical  Examiner  A. Facility Name (If not institution, give street and number)  Gilchrist Center  S. Social Security Number  126 26 2519  Usual Residence of Decedent  10a. State  10b. County  MD  Howard  10c. City, T  MD  Howard  10c. City, T  MD  Howard  10d. Street and Number  5235 Hesperus Drive  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  James McDonough  19a. Informant's Name/Relationship (Type, Print)  Tim McDonough/Son  20a. Method of Disposition  1 Wigurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  23a. Part1. Enter the disease, or complications that mused the death, shock, or heart failure. List only one cause on each line.									of Death		'						
	The Bulletines   Certificate of Death   Seg. No.																
eral	5				7. Age	(In yrs. last b						8. Date of B (Month, L	ay, Yea	ir)	9. Birthp	place (Stantry)	ate or Foreig
ctor				163 M 2 L F	6	8	Yrs.					Dec 4	, 19	35	New	York	
-31	$\vdash$					10c City To	wn or Lo	cation							1	Ind foeid	le City Limits
# L		104. State 100. C	County														
1 o	L	MD Ho	war	d		Colu	mbia										
. Sire	1									_			10g. (			-	
20		5235 Hesperu	ıs D	rive				2	2104	4				Unite	ed St	ates	5
ner		11. Marital Status		12. Was De	cedent E	ver in U.S.	13.	Was Dece	dent of H	lispanic C	rigin? (Sp	ecify Yes or N Rican, etc.)	10-				n,
3		1 Never Married 2	Marri	ed 1X Yes	2 🗆 N	0		_									
3		3 ☐ Widowed 4 ☐ Di	ivorced	Year or	Dates:1	953 <b>–</b> 56			-3-0					Зроси	' Wh	ite	
je		15. De (Specify only	ecedent	's Education	0	16	a. Dece	dent's Usua	af Occup	ation during mo	st of work	ina	16b.	Kind of B	usiness/In	dustry	
J dr	-			College						d)		-					
No.	L	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Exec	utive	}	,				_		fens	se
e C		17. Father's Name (First, A	Middle, I	Last)									e, Maid	en Suman	пе)		
0.0		James McDond	ough							Vivi	ian B	ricker					
1		19a. Informant's Name/Re	elationsh	nip (Type, Print)		19	b. Mailir	ng Address	(Street	and Num	ber or Run	al Route Num	ber, Cit	y or Town,	State, Zip	Code)	
		Tim McDonouc	ah/S	on		9	328	Sprin	o W	ater	Path	Jessu	o, M	ID 20	794		me of Death  :10 A  itate or Foreig  k  ide City Limits  ]Yes 2 X No  S  an,  Se  TH Inc  21 0 43  xximate all Between and Death  Year  de of death?  4 □ Unknown  dings available noi cause of o
	0-					20b. Place	of Dispo	sition (Nar	ne of	- 1						own, Stat	State or Foreign Ck  State or Foreign Ck  side City Limits Yes 2 No.  PSE  The State of death?  Year  Year  Year  Junknown andings available on of cause of
					n State			,			2-3-	2004	CI	arks	ville	_ МГ	)
	-				- M											•	
Duce		21. Signature of Furieral S	0/	7 - 47	06	01044											
u,	-	Shim (	000	mo m	1	abi disabi D	,							ill C.	тсу,		
		shock, or heart failur	ease, or re. List	complications that only one cause on	each lin	е.			-	-		or respiratory	arrest,			Interval	Between
n	Ť	disease or condition			es	och	age	- al	C	anc	er					ye	ans
		resulting in death)		Due to	o (or as a	a co <b>b</b> sequenc	e of									0	
er		Commentation line condition		, n													
je .		if now landing to immedia	ito		(or as a	consequenc	e of										
Ē		Cause (Disease or injury that initiated events		c =													
EX	J	resulting in death) Last		Due to	o (or as a	a consequenc	e of):										
ä				d													
Medicai Examin	1																
			nant					_						23d. Da	ite of delive	ery	
<u>a</u>		in the past 12 month								У				Mo	onth	Day	Year
hysic									.,								
		Part II. Other significant of	conditio	ons contributing to	death bu	at not resulting	j in the u	nderlying o	ause gn	ven in Par	t I.	23e. Dio	tobacc	o use con	tribute to ti	he cause	of death?
								,	3.					_			
leted												100000000000000000000000000000000000000		1			.cco
ple												aut	opsy	1	prior to co	psy findi mpletion	ngs availabl of cause of
Compl																2 🗆 No	
			medical							26. Pla	ce of Deat						
, e		examiner/															
0 8	١.	1 ☐ Yes 3 No		Hospitaf: 1	Inpatie	nt 2 ERV	Outpatier	nt 3 DC	Ott Ott	her: 4 🗆 t	Nursing Ho	me 5 Re	sidence	6 Oth	ner (Specif	y) Ha	Spice
0	1	1 Yes No 27. Manner of leath	] Pendin	28a. Dat			Outpatier  Time o		Ott 28c. Injui	ry at	Nursing Ho	me 5 Re 28d. Describe				y) Ho	spice

To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune

Division of Vital Records, P.O. Box 68760,

McDsnough, Harred Baltimore, Maryland 21215-0036

State Registrar

Certification

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

6 Could not be determined

29c. License number 1)25205

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January 29, 2004

who convileted cause of feath (ftem 23a) (Type, Print) 6201 N. Charles St. Balts, and 21204

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrar's Signature 31. Date filed (Month, Day, Year)

JAN 3 0 2004

		•	•	
For	State of Maryland / Department of Health and N. 27,28a-f. Per ME. C82862/428/94es of Death	Mental Hygiene	2001.	01.1.5
1 - State Unpend Item#23a	,27,28a-f,Per ME,G828G2/47/0478 of Death	Reg. No.	COUR	04401
1 Decedent's Name (First Middle Last		2. Date of Death		3. Time of Death

DA	P		For Unpend Item#2	State o 3a,27,28a-	of Mary -f,Per	land / Dep ME,G828 <sub>6</sub> 2	artment o	f Health a of Death	nd Me		ene 2	001	04450
			Decedent's Name (First, Middle, L	ast)					2	. Date of Death			3. Time of Death
	Physici		GILBERT J. 1	ATCHAFT.					1.	Month JANUARY	Day 5 - 20	Year 04	3:11 a M
	/Medic Examir	9	4a. Facility Name (If not institution, g		ımber)		4b. City, Tow	n, or Location of		712.011112		nty of Death	
	Examil	er	PENINSULA REGION			NTER	SALISE	BURY			WICO	MICO	
	Funeral			Sex		yrs. last birthday	Il Under 1 Ye	ear If Under 2		. Date of Birth			place (State or Foreign
	Director		210-12-9060	1 <b>X</b> M 2□F	76	Yrs.	Months Da	ys Hours	Min.	-28-19	297)	PENN	ISYLVANIA
2,5			Usual Residence of Decedent				<u> </u>						
	ahow		10a. State 10b. County		100	c. City, Town or L	ocation						10d. Inside City Limits
	Mar.	to	DELAWARE SUSSEX	ζ		DAGSBOR	RO						1 ☐ Yes 2X No
	r 28,	Director	10e. Street and Number				10f. Zip Coo	le		10	g. Citizen o	of What Cou	intry?
	72 hours after death with the Maryland natural', or items 23a or 28a-f ahow alcal Exeminet must be notified at	ai D	2 DOGWOOD ESTATI	ES			199	39			US		
	ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever	in U.S. 13.	Was Decedent	ol Hispanic Orig Cuban, Mexican,	in? (Specif	y Yes or No-		ace - Amer	
9	after or ite	Ē	1 ☐ Never Married 2X Married	1 ☐ Yes	2 X No				, Fuelto rik	Jan, etc.)			_
93	art, o	by	3 ☐ Widowed 4 ☐ Divorced	Il Yes, G Year or [	oates:		1 □ Yes 2 🛚	No Specify:			Spec	ciry: W	HITE
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest of		)	16a. Dece	edent's Usual Oc	cupation one during most	of working		6b. Kind of	Business/I	ndustry
215	within 7	ple	Elementary/Secondary (0-12)		College (1-4or 5+)								
21	gien gien er th	no.	8	111-221		SHEET	METAL	MECHANI	C		CONS	STRUCT	'ION
b	be filed stal Hygi od other	Be (	17. Father's Name (First, Middle, La							First, Middle, M.	aiden Sum	ame)	
<u>a</u>	uld b Venta rrked rrked	10	GILBERT J. MICH	IAEL									
Maryland	s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Esa		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ing Address (Str	eet and Number	r or Rural F	Route Number,	vn, State, Zi	p Code)	
	1 and 2 Health em 27 i		SYLVIA A. MICHA	AEL/ WIF	'E	2 DC	GWOOD E	STATES,	DAGS	BORO, D	ELAWA	RE. 1	9939
re	of He of He fitem r oth		20a. Method of Disposition		2	0b. Place of Disp MELSON ICS	osition (Name o	f place)	Dat	e 2	0c. Locatio	n - City or T	own, State
Ĕ	Pages nent of I int: If the iry or o		1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control Co		State	MELSON S HENLOPEN	CREMAT	ORY 1-	-6-04	F	'RANK F	ORD D	ELAWARE
Baltimore,	그 는 은 글		21. Signatury of Funeral Services	insol //	1			UNERAL	-				3
ä	Department Department	W. 1	1 / Kings	Mila				ST, FRAI					
	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Card	iovascu	death. Do not er	icating H	-					Approximate Interval Between Onset and Death
	sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.		nsequence of):							
8760,	# > #	dical Ex	resoluting in court, east	d	Oras a co	nsequence of):							
Box 6	leath certifica attending ph I for use as t	an/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			□Ectopic pregna	ancv				Date of deliv	•
o.	that the deal ed by the att detached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown		nant at time		Other (specify					Month	Day Year
rds, P	es gu	by	Part II. Other significant conditions	contributing to	death but no	t resulting in the	underlying cause	given in Part I.			accoluse co s 2 🗀 No		the cause of death?
Record	e law has b	Completed								24a. Was an autopsy	ed?	b. Were aut prior to e death? 1 X Yes	opsy findings available ompletion of cause of
Vital	icien: Th certificate rector, pag	Ö	25. Was case referred to medical					26 Place	of Death /	1 Yes 2 Check only one	No No	Alles	20110
Ξ		0 8	examiner?	Hospital:	Unnationt	2 ER/Outpatie	ant 3CT DOA	Other		5 ☐ Resider		Other (Spec	i6d)
of		-	27. Manner of Death	28a, Date	Inpatient of Injury		of found 28c.			d. Describe how			119)
Division	Attending Frideath. actor: After	catlor	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	1/2/0	nth, Day Ye 4 four	id 3:11	ам	1 ☐ Yes 2 ₹ N		subject f			
Divi	Dirt o	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ding etc. (S	At home, larm, s pecify) spital ro	on	ice	100	City or Town,	State)		cal Center,
	he Hospital in 24 hours he Funerel pletely filled	edical	29a. Certifier 1 Certifying (Check only one)	aminer: On the	ne best of m basis of exa nner stated.	y knowledge, dea mination and/or i	th occurred at the	ne time, date and my opinion, deat	d place, an	d due to the car	use(s) and	manner as	stated.

To t To t

29c. License number 29d. Date signed (Month, Dey, Year) OCME

**JANUARY** 6,2004

JANUARY 6,2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THE BORE M. KING

III Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 2004

32. degistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Lest) 2. Data of Death Month 1 / 24 / 2004 **Physician** Vivian Lorian Miller 1312 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Worcester Ocean Pines 88 Brandywine Drive If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** Months Days Hours 1□ M 2X F 554-58-7189 Yrs. 59 Director Usual Rasidance of Dacedent with the Marylend 10a. Stata 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryler Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Madical Examiner must be notified at once. 10d. Insida City Limits Yes 2 No **Funeral Director** MD Worcester Snow Hill 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 21863 USA 103 S. Church Street Apt. 103 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status Was Dacadent Evar in U,S. Armed Forcas? Race - Amarican Indian, Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yas 2 XNo Specify: <u>\$</u> 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Specialist Restaurant 12 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be Helen Smith **Woodrow Carter** 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 88 Brandywine Dr. Ocean Pines, MD 21811 Barbara Scheleur (sister) 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory 01/29/2004 Frankford, DE 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Licensee The Burbage Funeral Home 108 William Street Berlin, MD 21811 28a. Part 1. Entar the diseasa, or complications that cause if the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart dilure. List only one cause on a continue. Approximate Interval Betw Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical COPD EW YEARS Examiner Due to (or es a consequança of): Physician/Medical Examiner ettending physiclen end for use es the burial-transit or Attending Physician: The law raquiras thet tha death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disease or injury that initiated avants Dua to (or es a consequance of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to complation of causa of deeth? pega 2 should 24a. Was en autopsy parformed? 1 ☐ Yas 22 No 1 ☐ Yes 2 ☐ No certificate 25. Was casa referred to medical Be 26. Place of Daath (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) residence sister's Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yas 2 No this 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending invastigation after deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledga, deeth occurred at tha time, date and place, and due to the ceuse(s) and manner as stated.

27 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad. edical 29a. Cartifiar 29b. Signatura and titla of cartifier 29c. Licansa numbar 29d. Date signed (Month, Day, Yaer) D 06241 1-27-04 30. Nama end address of person who completed causa of death (Itam 23a) (Type, Print) 0. DOROTHY HOLZWOTTH SNOW HILL MD 21863 MJ. SNOW ST, 31. Data filed (Month ∰gistrar's Signatura State 2004 Melver Registrar

DHMH 16 Rev 6/95

		1 - State Registrar Amend Item#2  1. Decedent's Name (First, Middle, La			704 G/G	rtificate	e or i	Jeath		2. Date of D	Reg. No.	004	3. Time o	t Death
Physici		C.A. D	LIK							Month	Dey	Yeer 2.004		
/Medic Examin		4e. Fecility Name (If not institution, give		er)		4b. City,	Town, or	Location	of Death	JANUA		ity of Death	1	
		UNIVERSITY OF N	1 ARYLA	ND		BA	LT1	MOR	ت					
Funeral		5. Social Security Number 6. S		Age (In yrs. I		If Under Months		If Under Hours		8. Date of B (Month, D	irth Day, Year)	9. Birth	plece (State	or Fore
Director		218-29-5260 Usuel Residence of Decedent		16	Yrs.					Jan.1	,1988		yland	<u></u>
Now III		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside C	Dity Lim
a-1-a	ctor	Maryland Mont	gomery	9	Gaith	ersbu	ırg						1X Yes	3 2 🗆 1
or 28	Dire	10e. Street and Number				10f. Zip		_			10g. Citizen o	f What Cou	intry?	
permit. Fages I and 2 should be lied within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if them 27 is marked other then *neturel*, or iteme 23a or 28a-f show eny injury or other traumatic event. In a Medical Examiner must be motified at once.	Funeral Director	19331 Keymar Wa			0 10		208				USA			
item in	-un	11. Marital Status  1   Never Married 2  Married	12. Was Decede Armed Force 1 ☐ Yes 2	s?	S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar	gin? (Sp. n, Puerto	ecify Yes or N Rican, etc.)	lo-   14. Ri   Bi	ace - Amer lack, White		
er', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	ZNo	Specify:			Spec	eify: Wh	ite	
netur	Completed	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usua	l Occupa	ation	t of work	ing	16b. Kind of	Business/Ir	ndustry	
then the	nple	Elementary/Secondary (0-12)	Cotlege (1-4	or 5+)		kind of wor. DO NOT us			t of work.	ing	N	_		
Hygiene. Hygiene. Ither ther		17. Father's Name (First, Middle, Last				Unemp	7103		4. 11.	- (F) - A A C - A	Non			
ntal h	Be .	Anwar Mali								Sherz	e, Maiden Suma	ame)		
and Mental le marked o	ဥ	19a. Informant's Name/Relationship (			19b. Mailir	na Address	(Street a				ber, City or Tow	n State Zi	n Code)	
27 le		Amena Malik- N	•								urg,Md		886	
of Height Item		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Nam	e of	-		Date	20c. Location		own, Stete	
nent case		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specil		1169				* 1	L <b>-</b> 24	-04	Adelp	hi,M	d.	
Department Important: I any injury c		21. Signature of Funeral Service Lice	see/ //	1	22	. Name and	d Addres	s of Facilit	yUni	versa	1 II M	ortu	ary I	nc
I S E S B		Moen	11/aci	~		411Ke	nne	dy S	St,N	.W.,W	ash,D.	C. 2	0011	
hysician		23a. Part1. Enter the disease, or com shock, or heart failure List only Immediate Cause (Final	plications that cause one cause on each	sed the death n line.					,		arrest,		Approximate Interval Bet Onset and	tween
/Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	ience of):	crani	al I	mpe	Meny	ion				
Examiner		Sequentially list conditions	6. Subd	unal	Hema	tome	1							
sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or	as a consequ	ence of):						N. A.			
and Il-tran	Examin	that initiated events resulting in death) Last	c. Que to (or	as a consequ	and	njun	<del>\</del>			23	HAMILE			
hysician and the burial-transit		l l			01,00	) (	)			A MEDICAL				
g phy:	edic	•	d					-	ak	0,4				
attending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregnar					Norton Re	de.	23d. D	ate of deliv	ery	
e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☒No	4 Pregnant	2 ∏ Fetal at time of de		Ectopic pre Other <i>(spe</i>		J.	O TION		M	lonth	Day	Year
ed by the detached	hys	9 Unknown	9∐ Unknowr					NO AL	tie.					
p p eq	þ	Part II. Other significant conditions of	ontributing to death	n but not resul	lting in the ur	nderlying ca	use grve	n in Part I.		23e. Did	tobacco use cor		_	
s peed should	ted									1	Yes 2 WNo	3 Prot	oably 4 🔲	Unknov
has b	Completed									24a. Was	psy	prior to co	psy findings mpletion of c	availal cause c
										1 Yes	omed? 2/2 No	death? 1 ☐ Yes	2 🗆 No	
is certii directo	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No	Hospital:				Othe	1		(Check only				
<del>⊊</del> ख	-	27. Manner of Death	1 X Inpa 28a. Date of In (Month, I		R/Outpatien 28b. Time of		c. Injury Work	4 🗆 1401			idence 6 Ot		(y)	
r death. ector: After by the funer	atio	1 □Natural 5 □ Pending 2 ☑ Accident investigation			Injury ું.પૂર્પા	М		? 'es 2.5⊘t	No 1	pussers	er in a	aluci	ie	
	Certification:	3 Suicide 6 Could not be determined	28e. Place of		ne, farm, stre	et, factory,	office		1	28f. Location (	Street an um wn, State)	ber or Rura	i Route Num	nber,
hours after inerel Dire y filled in by	Cer			Stre	et					7625 W	nets tono	N 1 1 3 10 1	The same of the sa	D
4 1 0	edical	(Orack Only Z   Medical Exal:	ysician: To the be niner: On the basis	i or examination	vledge, death on and/or inv	occurred a	t the timi	e, date and	d place, a	and due to the	cause(s) and m	anner as s	tated.	(2)
within 24 hours To the Funerell completely filled	Med	29b. Signature and title of certifier	and manner	stated.						31 11/0 11/10,				',
To S	_	255. Signature and title of certifier				_	C) O I		120		29d. Date sign			
(2)		30. Name and address of person who	completed cause	I dooth /lter:	22a) (Turns 1		00.	21	150		January	2	3 2	00
d J		M and address of person who	withherea canse o	i death (Item )	دعتا (۱۷۵۹, ۱	Print)   (2637		2			LET	212	77. 1	
V					At a control of the c					A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Month Year **Physician** 3:30 AM Menzies 2004 Jan uon Mar, ta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 61 Baltimore Hospital University Maryland 8. Date of Birth (Month, Day, Year)
SEPT. 3,1947 If Under 1 Year Months Days 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 🛣 F Hours 56 085-38-4514 Yrs Director NEW YORK Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MARYLAND

10e. Street and
28797 1 Yes 2 No TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 28797 OUTRAM STREET 21601 U.S. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by es. Give Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) fited within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSPICE 12 COORDINATOR OF VOLUNTEERS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other you injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE RAY PECK ANN WANNER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. MICHAEL S. MENZIES/HUSBAND 28797 OUTRAM STREET EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREM. CTR JAN. 25, 2004 CHESTER, MD 21619 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** crebra anuem resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy rmeo/ 2 ☑ No certificate 212 No 1□ Yes 1 TYes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred Hospital or Attending Injury 5 Pending death. 2 No 1 Yes 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the

State Registrar

29b. Signature and tile of certifier

31. Date filed (Mor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 6

ames

DHMH 17 Rev 1/2001

2

**ORIGINAL** 

M.D.

32 Registrar's Signature

29c. License number

22 South Greene Street

29d. Date signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7:30 P 2004 ESTHER D. MORELAND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HYATTSVILLE 3606 GRAMBY STREET If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 1 29 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🔯 F 66 MARYLAND Director 215-64-3211 Usuel Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Set 27 is marked other than "natural", or items 23a or 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or items 23e or 28e-f show XXYes 2 ☐ No Directo PRINCE GEORGE'S HYATTSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20784 3606 GRAMBY STREET by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give 14. Race - American Indian, Black White etc. 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 34 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12THHOME MAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ELIZA JOHNSON JAMES JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Heam. MARY MONROE/DAUGHTER 5012 BLACKFOOT PLACE COLLEGE PARK, MARYLAND 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages 1 □XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 1-22-04 CHELTENHAM, MARYLAND ⁴ 4 □Donation 5 □Other (Specify) MARYLAND VETERANS 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Ma Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Malignant Brain Tumor resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Completed by Physiclan/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9□ Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2X No Hospital or Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD19464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin McGrail 3800 Reservoir Road, NW Washington, DC 20007 31. Date filed (Month, Day, Year)

JAN 2 8 2004 32. Registrar's Şignature State

DHMH 17 Rev 1/2001

Registrar

		1 - State 2-4-04 Registrar Amend #'s10e	.19b.Per Fam.PGC cr	Cert	tificate of	Dealli	2. Date of Dea	Reg. No.	3. Time	e of Death
Physici		Curtis Leon					Month January	Day	Year	55 A
/Medio		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Deatl		4c. County		JJ <u>R</u>
Examili	ier	Holy Cross Hos			•	Spring			gomery	
Funeral	1		. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	r If Under 24 Hrs.			9. Birthplace (Stat Country)	te or Fore
Director		578-84-3623 Usual Residence of Decedent	1⊠M 2□F   47	Yrs.	Months Days	Hours Min.	August	23,195	6 Washin	gton
show at at	ō	10a. State 10b. County		y, Town or Loc					10d. Inside 1 📆 Y	e City Lim es 2 □ I
288	ect	Maryland Prince	George Cap	itol He	10f. Zip Code		1	10g. Citizen of V	What Country?	
3a or		3907 Alice Stree	t		2074	3		United		
E 5	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13, W	as Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No-	14. Rac	ce - American Indian, ck, White, etc.	
natural', or items 23a or 28a-f show iteal Examiner must be nutified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			☐ Yes 2€ No		o radan, etc.)	Specify	TO 1 . 1-	
natur Ilcal	eted	15. Decedent's (Specify only highest	Education	16a. Decede	ent's Usual Occu	upation a during most of wor	rkina		usiness/Industry	
rthan "c	Completed	Elementary/Secondary (0-12) Twelth	College (1-4or 5+)	Truck	O NOT use retire Driver	during most of wor ed)	9	D.P.I. Compar	Distribut ny	ing
other	BeC	17. Father's Name (First, Middle, La	ist)				ne (First, Middle,		ne)	
Venta	To B	George Mickle				Barbara	Robinsor	1		
Department of Health and Mental Hygiene. Important, or items 23s or 28s-1 show important: If Item 271s marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be neditied at ances.		19a. Informant's Name/Relationship Denise Mickle/W		19b. Mailing	Address (Stree Ellis Alice Si	tand Number or Ru treet Cap	<sub>Ira/Route Numbe</sub> itol Hei	r, City or Town, ghts MD	State, Zip Code)	
f Heal		20a. Method of Disposition	20b. F	Place of Disposi	ition (Name of atory or other pla		Date	20c. Location -	City or Town, Stete	
nt: If		1 🔀 Burial 2 ☐ Cremation 3  '4 ☐ Donetion 5 ☐ Other (Spe	THOMOVAL HOM State		n Cemet	Janu		Brentwo	od,Maryla	nd
Departin Importa any inju		21. Signature of Funeral Service Lic		22.	Name and Addr	ess of Facility R	obert G.		Funeral H	ome.
		23a. Pert1. Enter the disease, or co	omplications that caused the deat			Hope Rd ing, such as cardiac			Approxim	nate
nysician		shock, or heart failure. List or Immediate Cause (Final	•						Onset an	nd Death
Medical		disease or condition resulting in death)	Pancreatic ( Due to (or as a conseq						2-1/2	Yea
xaminer										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
icien and burial-transit	Examiner	that initiated events	c							
urial-	EX	resulting in death) Last	Due to (or as a conseq	uence of):						
hysic the b	lical		d							
been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Med	IF FEMALE:								
e attend id for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3 🗆 E	Ectopic pregnanc	су		23d. Dat Mo	te of delivery onth Day	Year
the a	slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5∐(	Other (specify) _				,	
een signed by the nould be detache		Part II. Other significant condition	s contributing to death but not res	ulting in the unc	deriving cause or	Ivan in Part I	23e. Did to	bacco use cont	nbute to the cause of	of death?
signe d be	l by	,			30.1, mg 04400 g.				3 ☐ Probably 4	
peen	etec						04-146-			
has je 2	Completed						24a. Was autop	SV I	Were autopsy finding prior to completion o death?	as availa
certificate ha							1 ☐ Yes	2 🖾 No 1	1 ☐ Yes 2 ☐ No	
this certific	Be	25. Was case referred to medical examiner?	Hospital:		0:	thor	ith (Check only or			
44	P.	1 Yes 2 No 27. Manner of Death	1 ₺ Inpatient 2 □	ER/Outpatient 28b. Time of	00 000	4 🗆 (4013)  g	lome 5 Resid			
al d	lon	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju	ork? ☐Yes 2 ☐No	200. 200010011	ow injury occurr	100	
After fune	62	3 Suicide 6 Could no	t be 29 p. Place of laine. At he	ome, farm, stree			28f. Location (S	treet and Numb	er or Rural Route N	umber.
After fune	0		building, etc. (Specifi	y)	or, ractory, ornoc		City or Tow			31113 (31)
After fune	ertifica	4 Homicide determine				me, date and place	, and due to the o	ause(s) and ma	inner as stated	
After fune	lical Certification;	29a. Certifier Check only 2 Medical Ex	Physician: To the best of my kno eminer: On the basis of examina	wledge, death of tion and/or inve	occurred at the t estigation, in my	opinion, death occu	rred at the time, o	date and place, a	and due to the cause	Θ(\$)
After fune	Medical Certifica	29a. Certifier (Certifying	Physician: To the best of my kno eminer: On the basis of examina and manner stated.	wledge, death of tion and/or inve	estigation, in my	opinion, death occu			and due to the cause	
Iter death. irector: After n by the funer	edical	29a. Certifier Check only 2 Medical Ex	eminer: On the basis of examina	wledge, death of tion and/or inve	estigation, in my	opinion, death occu		29d. Date signed	and due to the cause	
After fune	edical	29a. Certifier Check only 2 Medical Ex	eminer: On the basis of examina and manner stated.	tion and/or inve	29c. Licen D4765	opinion, death occu ise number		29d. Date signed January	and due to the caused (Month, Day, Year, 2004	

			riease	State of Ma							9	·•
			1 = For State Registrar	Otate of Mid	-	•	ate of		rivicitairi	Reg. No	200	6 06656
	Dhuaisi		1. Decedent's Nama (First, Middle, La	,					2. Date of Month		10/4	3. Time of Death
	Physici /Medio		Robert Emmett Mo						Janua	ry 26	, 2004	8:15 a м
£	Examir	er	4a. Facility Name (If not institution, giv Villa Rosa Nursin				City, Town, o tche11	r Location of De	eath		County of De	
	Funeral		5. Social Security Number 6. S		(In yrs. last birth	day) If U	nder 1 Year	If Under 24 H	Irs. 8. Date of	Rich	0.5	George's  Birthplace (State or Foreign Country)
П	Director		009-09-7959	1 💢 M 2 🗆 F	85 Yr	s. Mon	ths Days	Hours M	in. Nov. 5	Day, Year 191	8 V	ermont
	and #		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Prince	George's	Mitchel	lvil1	e					1X Yes 2 □ No
	or 28g	Director	10e. Street and Number				. Zip Code			10g. C	tizan of What	Country?
	ath wi		3800 Lottsford V				207			U.S		
	items items	-une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 XYes 2 N		13. Was D If Yes,	ecedent of H specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ar Black, Wi	merica <i>n In</i> dian, hite, etc.
99	ours at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Y€	s 2∑No	Specify:			Specify: W	Mhite
Maryland 21215-0036	within 72 hours after death with the Maryland ane. ttan "naturel", or items 23a or 28a-f show ta Mudical Evanirar maal be rodified at	Completed by Funeral	15. Decedent's Ed (Specify only highest gra		1 (0	Give kind o	Usual Occup	durina most of v	vorking		(ind of Busines	•
121	within ene. than	ldmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	te. DO NO	T use retired	<sub>"</sub> agement			my-Air	Force Service
ğ 2	illed Hygi other	Be Co	17. Fathar's Name (First, Middle, Last)	)			, o man		lame (First, Midd			Delvice
/lar	Menta Menta arked	To B	Thomas Francis Mo	rris				Margar	et		Pow	vers
lan.	2 sho and is my		19a. Informant's Name/Relationship (						Rural Route Nun			
	1 and Health em 27 ther t		Margaret Ann Bole 20a. Method of Disposition	s - Daught	20b. Place of D	1409 (	Cleary	Lane,	Mitchell Date			land 20721
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, It a Modical Examinal mail by rollified at Once.		1 🖾 Burial 2 ☐ Cremation 3 🔯 14 ☐ Donation 5 ☐ Other (Specif		cemetery, Calvary	crematory	or other plac	1				
alt:	mit. P partm portar y injur		21. Signature of Funeral Service Licer		Carvary				2004 asch's E			Vermont P.A.
<u> </u>	Depar Impo eny ir		Claudette	Darch La	ning	4739	Balti	more Av	e., Hyat	tsvi		
1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do not	enter the			iac or respiratory	arrest,		Approximate Interval Between Onset and Death
2.0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Athe	visillet	"	Boli	i mla	Dise			pinotes
**	Examiner				consequence of)	•						
365	D H	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a	Consequence of)							
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of)					_		
760,		caiE		d		,						
89						- 11	Mille-					
Вох	ath cer ttendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o		3 ☐Ectopi	ic pregnancy			- 1	23d. Date of d	•
0	at the dea by the a tached for	ysic	1 Yes 2 No	4□Pregnant at t 9□ Unk <i>n</i> own	ime of death	5 Other	(specify)				WORLD	Day Year
О.	The law requires that the death certifica ste has been signed by the attending ph bage 2 should be detached for use as th	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	e underlyir	ng cause give	en in Part I.	23e. Dio	tobacco i	use contribute	to the cause of death?
Vital Records,	v requires been sign should be								. 10	Yes 2	□No 3□I	Probably 4 Unknown
ဓင္ငဝ	e law re has ber pe 2 sho	Completed							24a. Wa	is an opsy	24b. Were a	autopsy findings available o completion of cause of
<u>~</u>	: The I cate ha	Con							per 1 ☐ Yes	formed?	death?	
	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Othe		eath Check on			
o	g Phy er this	-	27. Manner of Death	28a. Date of Injury		e of	28c. Injury Work	4 Nursing	Home 5 Re			eecify)
jo	Attending I death. ctor: After y the funer	atlo	1 Natural 5 Pending investigation		Yee <i>r)</i> Inju	M		res 2 □No				
Division of	I or Attend after death I Director: / d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify)	, street, fac	ctory, office		28f. Location City or T	(Street an	d Number or F	Rural Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.		29a. Certifier Certifying Ph	ysician: To the best of	f my k <i>n</i> owledge d	eath occur	red at the tim	e, date and nie	ca, and due to th	e Carreo/o	and manner	ac stated
	he Ho n 24 h he Fui	Medical	(Check only 2 Medical Exam	ninar: On the basis of e and manner state	examination and/c	r investiga	tion, in my op	pinion, death oc	curred at the time	, date and	place, and du	ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifler	un		. 15	29c. License	number		29d. Da	e signed (Mor	nth, Dey, Year)
			· W /		M	4)	D322	261		Janu	ary 28	, 2004
_	6		30. Name and address of person who o				1	14	T 1		00701	
	Sta	te	Richard J. Feldma 31. Date filed (Month, Day, Year)	n, MD 9500 32. Registrar		ııs R	oad, S	re. A4,	Lanham	, MD	20706	
1	Registr	ar	JAN 2 9 2004	Marie	A Coo	de						

State of Maryland / Department of Health and Mental Hygiene ?

	0	1	1	-	-
9	1 1	2.8	1 1	1000	
8		10.7	-	1	

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

**Funeral** Director

the Maryland

ral, or itema 23s or 28s-f show Examiner must be notified at Director death with

Funeral

þ

Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or fren any injury or other traumstic avent, the Medical Exercited ADER.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

attending physician and for use as the burial-transit The law requires that the death certificate be executed the page 2 To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifica in by t

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed Be P Certification; Medical

1- State Registrar Unpend Item#23a,27,Per ME,0829,3/16/8/tificate of Death 2. Date of Death 3. Time of Death Yee 1446 P <sup>M</sup> JANUARY 25, 2004 Roy James Milliner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) 5. Social Security Number 6 Sax 8. Date of Birth (Month, Day, Year) Months 1X□M 2□F 9/18/1952 Philadelphia,PA 162-42-8474 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Bowie, 1 X Yes 2 No Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20721 15401 Jenkins Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No t Yes, Give] 973—1978 Year or Dates. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: SpecifyBlack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Motor Vehicle Operator Federal Government 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fay Parnell Bennie Milliner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15401 Jenkins Ridge Road, Bowie, Maryland 20721 Donna Smith Milliner (wife) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cometery, crematory or other place)
Quantico Nat'l Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify)
21. Signature of Funeral Service Licenses 2/2/04 Triangle, Virginia 22. Name and Address of Facility
Pope Funeral Homes, PA 15538 Marlboro Pike, Forestville, Md 20747 Tonn 2 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition Atherosclerotic Cardiovascular Disease resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) tF FEMALE: 23c. tf yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 2 ☐ ER/Outpatient 3 X DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

LING LI. 31. Date filed (Month, Day, Year) FEB 0 2 2004

his.

29b. Signature and title of certifier

29a. Certifier

MID 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

m. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JANUARY 27, 2004

			For State Registrar	State o	f Maryla		artment of H		Mental Hy	ygiene Reg. No.	2004	04458
	<b>S</b> 1		1. Decedent's Name (First, Middle						2. Date of D Month		Year	3. Time of Death
	Physicia /Medic		Ruth		ietta	Mohle:		·	Februa	ry 9	2004	1:08 A M
	Examin	er	4a. Facility Name (If not institution		mber)		4b. City, Town, o	or Location of Dea			ounty of Death	
			Reeders Memor: 5. Social Security Number	Lal Home	7. Age (In yrs	. last birthday	If Under 1 Year	Boonsbo	S. R Date of B	irth	Washin	place (State or Foreign
E	Funeral Director		214-10-2094	1□M 2□xF	87	Yrs.	Months Days	Hours Mi	Nov. 8	, 1916	Mar	yland
7			Usual Residence of Decedent		100 0	ity, Town or L	anation (					10d. Inside City Limits
Mohle	show	č	Maryland Was	shington	100. 0	ny, town or L	Boonsb	oro				1 ☐ Yes 2 ☐ No
3	the Mi	ect	10e. Street and Number	- IIIII COII			10f. Zip Code	OLO		10g. Citize	n of What Cou	
	th with 23a or		141 South Main	Street				1713			U.S	•
è	within 72 hours after death with the Maryland iene. rthan "natural", or ttems 23a or 28a-f show it e Medical Exercirer must be notified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or Norto Rican, etc.)	10- 14	. Race - Ameri Black, White,	
38	s after , or the	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes	2 No		1 ☐ Yes 2 🖾 No			i	pecity: Whi	
W, Nebren 1d 21215-0036	hour:	ed b	15. Deceden		pates:	16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/In	ndustry
7 /e	nin 72 In "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+\	(Give	kind of work done DO NOT use retire	during most of w d)	rorking			,
), NE 2121	TO 70 = -	Som	II	Joney (		Home	emaker				Home	
	d 2 should be filed th and Mental Hygi 7 is marked other traumatic event, I	To Be (	17. Father's Name (First, Middle, Roy Bernard V		•				<sub>ame (First, Middl</sub> Lice Fei		ımame)	
F ryla	should be ind Menta imarked umatic ev	2	19a, Informant's Name/Relations		-	10h Maili	ng Address (Street				Town State Zi	o Code)
Ma	₽ <b>₽ ₽</b> ₽		Raymond Wayne		on		Ninth Av					<i>p</i> (3335)
E ē	s 1 an if Heal item 2 other	1 3	20a. Method of Disposition		20b.	Place of Disp	osition (Name of		Date	20c. Loca	tion - City or T	own, State
le ' /			1 □tBurial 2 □ Cremation 1 □ Donation 5 □ Other (S		State MO	unt OI	natory or cher ola LVet Ceme	fery Fel	o. 11, 2	004 F	rederio	ck, MD
bme Balti	permit. Page Department of Important: ff any injury or ance.		21. Signature of Funeral Service	Licensee	1 1		2. Name and Addre Keeney &	ess of Facility	1 Funera	1 Home		
bn	205 2		23a. Part1. Enter the disease, or	.C. gas	MO MO	0021						1701 —
-	00.0		shock, or heart failure. List	only one cause on	each line.		1			arrest,		Interval Between Onset and Death
	Physician / /Medical	V 12	disease or condition resulting in death)	a	Cor as a conse	mary	arley	Brsca	se .	-		yeare
1	Examiner			, Bus to	H	merte	usion					years.
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conta	quence of):						0
V	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	(							
8760,	be exelician a		Tosailing in dodiny Edit	Due to	(or as a conse	quence on:						7
687	ficate physics the	Physician/Medical		d								
Box (	n certii Inding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregi	nancy	⊒Ectopic pregnanc	.,		230	d. Date of deliv	•
œ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of		□Ectopic pregnanc □ Other (specify) _	у			Month	Day Year
P.O.	at the	Phy	9 Unknowh			autina in the c	undarkina sausa ar	on in Dart I	23a Did	tobacco usa	contribute to t	the cause of death?
Š,	signer bed	þ	Part II. Other significant conditi	van ced	A/2her	_	Dement	4 - 4		Yes 2 🛣		bably 4 DUnknown
Division of Vital Records,	v requ been shoul	Completed					,0,,,0		24a. Wa	san :	24b. Were auto	opsy findings available
Re	he lav e has age 2	dmc							aut per	formed?	prior to co death? 1 ☐ Yes	opsy findings available empletion of cause of
tal	an: T	Be C	25. Was case referred to medica	I				26. Place of D	1 ☐ Yes eath (Check only	2 No	T T T T T T T T T T T T T T T T T T T	2 NO
<u></u>	hystci nis ce I direc	To E	examiner? 1 ☐ Yes 2 No			☐ ER/Outpatie	nt 3 DOA		Home 5 ☐ Res	sidence 6	□Other (Speci	fy)
0	ing PI Víter tř unera		27. Manner of Death 1 Satural 5 ☐ Pendin	'9	of Injury oth, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury o	occurred	
isio	ttend death stor: /	ertification;	2 Accident investi 3 Suicide 6 Could		a of Injury - At	home farm st		]Yes 2 □No	28f Location	(Street and I	Number or Run	al Route Number,
Σį	after Direct	ertif	4 ☐ Homicide determ	build	ling, etc. (Spec	cify)	reet, factory, office		City or To	own, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one) Certifyin	ng Physician: To the Examiner: On the t	e best of my kr basis of examination	nowledge, dea nation and/or in	th occurred at the ti	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) ar , date and pl	nd manner as s lace, and due t	stated. to the cause(s)
_	ro the vithin roughle comple	Mec	29b. Signature and title of certification	5 1 1			29c. Licens			29d. Date s	signed (Month,	Day, Year)
	./		<b>&gt;</b>	VY			24	4996		Feb	9,200	54
_	15		30. Name and address of person						0771	202 40	0.0470	
			Dr. Zafar Malik 31. Date filed (Month, Day, Year	20311Lar	pans R Registrar's Sign	oad Boo	onsboro,	aryland	21/13	301-43	2-8470	
	Sta Registr		FEB 12	Ei.	Mess.		ante					

lore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ural', or Items 23e or 28e-f ehow | Examiner must be notified at

"netural",

ss 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. item 27 ie marked other than "netu other traumatic event, the Medical

Direct

Funeral

ል

Completed

Be

Maryland

Baltimorr Permit. Pages: Department of the importent: If ite any injury or of once.	1 ♣ Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	emoval from State	Resurrection
	21. Signatur of uneral Service Ucen	1	22. Name a
Ball permil Depar Impor	Muh Land 8	201-	9013
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line	ne death. Do not enter the mo
Physician -	Immediate Cause (Final disease or condition	PNEUMON	
/Medical Examiner	resulting in death)	Due to (or as a	consequence of):
executed in and intransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):
760,  b be execul sician and burial-trai	that initiated events cresulting in death) Last		consequence of):
S, P.O. Box 6876( se that the death certificate be igned by the attending physicic be detached for use as the but by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death 3 ☐ Ectopic p
ords, P., requires that seen signed be nould be deta	Part II. Other significant conditions cor	ntributing to death but	not resulting in the underlying
Division of Vital Records, P.O. Box 68760, a Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death. From this certificate has been signed by the attending physician and etery filled in by the tuneral director, page 2 should be detached for use as the burial-transit dical Certification; To Be Completed by Physician/Medical Examir	27. Manner of Death	lospital: 1 □ Inpatien 28a. Date of Injury (Month, Day	
Division c tel or Attending P is after death. el Director: After t led in by the tunera Certification;	1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		M v - At home, farm, street, facto
Divisio Division of Attendi 24 hours after death. 5 Funeral Director: A stelly filled in by the tudie of the form	29a. Certifier 1X Certifying Phys	sician: To the best of	my knowledge, death occurre

31. Date filed (Month, Day, Year)

JAN 3 0 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 27, 8:50P M 2004 Margaret Mykut 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) CECIL VA MARYLAND HEALTH CARE SYSTEM PERRY POINT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 28, 1920 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 ☑ F Yrs. Pennsylvania 83 184-16-2629 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 SYes 2 □ No New Carrollton Maryland | Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6410 Jodie Street 20784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces?

1 Syes 2 No1/14/43

If Yes, Give
Year or Dates: 12/20/43 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 □Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) <u>Private</u> 8th Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Mudryk Peter Mykut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine Ghessie 6410 Jodie Street, New Carrollton, MD 20784 (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/2004 Clinton, MD Cemetery and Address of Facility Rendon/Hale Funeral Home Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death de of dying, such as cardiac or respiratory arrest, UNKNOWN 23d. Date of delivery pregnancy Month Dav Year specify) 23e. Did tobacco use contribute to the cause of death? cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 🛛 No 1 Yes 26. Place of Death (Check only one) Other: 4 🛭 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) AOC 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) ory, office d at the time, date and place, and due to the cause(s) and manner as stated. on, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Manas / Drawle D42800 JANUARY 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 THOMAS BIONDO, M.D., 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

		For State Registrar	State of Maryland		rtificate				Reg	g. No. 20	04 0446
Physicia /Medic	al .	Decedent's Name (First, Middle, Last	JANIS ME	REDIT		Four or L	ocation of Dea	Jan	ite of Death onth IUary		
Examin	er	4a. Facility Name (If not institution, give Southern Maryland  5. Social Security Number  218-24-6738	Hospital	ast birthday) Yrs.	Clint If Under Months	On 1 Year	f Under 24 Hr Hours Mir	s. 8. Da	ite of Birth	Prince	e George 's  9. Birthplace (State or Forei Country)
Director	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Ge	10c. City	, Town or Lo		ts		Ju.	ly 23,	,1932   1	Nash. D.C.  10d. Inside City Limi  1 2Yes 2 1
h with the	ai Director	10e. Street and Number 7420 Marlboro Pike			10f. Zip				10	g. Citizen of WI	hat Country?
72 hours after death with the Maryland "natural", or Items 23a or 28a-f show oldal Exeminer must be rediffed at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates:		Was Deced If Yes, spec		anic Origin? ( Mexican, Pue Specify:	Specify Y into Rican,	es or No- , etc.)	Black	- American Indian, , White, etc. White
	Completed by Funeral	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication le <i>completed)</i> College (1-4or 5+)				on ring most of w Visor	orking		6b. Kind of Bus	iness/Industry
d 2 should be filed within the and Mental Hygene 27 is marked other than traumatic event, the M.	To Be C	17. Father's Name (First, Middle, Last) Will Meredith  19a. Informant's Name/Relationship (T	mo Print	10b Maili	a Addrass		Della	Godd	lard	aiden Sumame	State, Zip Code)
and 2 sh leaith and m 27 is m	. 3	Beth Gott/Cousin			Turke	y Hi			lata,	MD 206	
permit. Pages 1 and 2 Department of Health a Importent: If item 27 it eny injury or other tra		20a. Method of Disposition  1 □ Burial 2 🖫 Cremation 3 □ i  4 □ Donation 5 □ Other (Specify,  21. Spanature of Funeral Service Light	Removal from State Rive	emetery, ciei erdale (	matory or of Cremato	ther place) LY		27/200	4 Ri	iverdale,	MD
Depar Impo		Joh 7 Bo	ell	4	lll Per	nsylv	ania Ave	., Sui	itland,	neral Hon MD 20746	
Physician /Medical Examiner pennal-Itansit	ical Examiner	23a Part 1. Enter the disease, or companion, or heart failure. List only of the disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CON GS ES  Due to (or as a conseq  b. Due to (or as a conseq  c. Due to (or as a conseq  d	uence of):  OMY uence of):	PATE	lean 14	r fn	HUM	28		Interval Between Onset and Death
that the death certificate ed by the attending physical detached for use as the the the the the the the the the the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3[	⊒Ectopic pri ⊒ Other <i>(sp</i> i					23d. Date Mont	of delivery th Day Year
w requires that the been signed by the should be detache	b	Part II. Other significant conditions of		ulting in the c	anderlying ca	ause given	in Part I.	2			bute to the cause of death?  3 Probably 4 Agriknow
: The law requ cate has been page 2 should	Completed								4a. Was an autopsy perform	ed? de	fere autopsy findings availal for to completion of cause o eath? □ Yes 2₽\No
uing Physician: The After this certificate funeral director, pag	n: To Be	27. Manner of Death	Hospital: 124npatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time of Injury		Other	4   Nursing	Home 5	5 ☐ Resider	nce 6 Othe w intury occurre	
or Attending Physician: The law requires taller death.  Jinector: All the this certificate has been signed in by the funeral director, page 2 should be a	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st	М	1 🗆 Ye	s 2 □No		ocation (Stre lity or Town,		er or Rural Route Number,
To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical C	29a. Certifier 76 Certifying Ph (Check only one) 2 Medical Exert	ysicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, dear tion and/or in	th occurred evestigation,	at the time , in my opii	, date and pla nion, death oc	ce, and du curred at t	ue to the car the time, da	use(s) and mar te and place, a	nner as stated. nd due to the cause(s)
To th withir To th	Me	29b. Signature and title of cedifier	MD		290	DS:	Number 885		29	d. Date signed	(Month, Day, Year) 3/2004
-(3)		30. Name and address of person who of Vignary - S (Av) 31. Date filed (Month, Day, Year)	completed cause of death (Iten  NAMN 7501  32. Registrar's Signa			Rose	HO #3	307	Cur	Ton 1	ND 20735

DHMH 17 Rev 1/2001

Janier Merdith

			1 - For State Registrar AMEND ITEM  1. Decedent's Name (First, Middle, La	State of Mary #18 PER FH G82	land / De		lealth and	Mental Hyg	iene 200		
	Physici	_	Evelyn I	7	McMar		Month Februa:	Day Yea	r M		
>	/Medic Examin	_	4a. Facility Name (If not institution, giv	e street and number)	Moman	1	r Location of Deat		4c. County of De		
			Memorial Hospita	al		Cumberl	and		Alleg	anv	
	Funeral Director		5. Social Security Number 6. S 215-36-9213 Usual Residence of Decedent	ex 7. Age (III	n yrs. last birthda Yrs.	(y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1939	Birthplace (State or Foreign Country)	
	Maryland I show	tor	10a. State 10b. County Allega	1	oc. City, Town or Cur	Location nberland				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
:	a with the	i Direc	10e. Street and Number 21 Boone Street	1	21502	10	10g. Citizen of What Country? USA				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Separation of Heath and Mental Hygiene. Sny injury or other traumatic svent, the Medical Examinar must be notified at an once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	r in U.S.	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	merican Indian, hite, etc.		
Maryland 21215-0036	ithin 72 ho ie. ien "natur i Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	ation during most of wo						
7	led will have the har	Co	12		Hom	emaker	40 14-16-4-11-		Own Hom	<b>e</b>	
yland	ould be to Mental H barked of batic sver	To Be	17. Father's Name (First, Middle, Last, Humbird Gross				Fannie	Mae Rob	Maiden Sumame) by MeMannis		
, Mar	and 2 sh salth and n 27 is rr		19a. Informant's Name/Relationship ( Joseph McMannis	s husba	nd 21	Boone Str	and Number or Ru eet		City or Town, State erland	MD 21502	
Baltimore,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Ourial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, c	position (Name of rematory or other place emorial Park	ce)	2/9/2004	Cumberla		
Balt	permit. Depart Import sny inj		21. Signature of Funeral Service Lice	J Aur	lui	22. Name and Addre Scarpe 108 Vir	ili Funeral I	Home, PA	land, MD 21	502	
20.	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Indextrino.	b. Due to (or as a co	tic Consequence of):					Approximate Interval Between Onset and Death	
	es that the death certificate be executed greed by the attending physician and be detached for use as the buriat-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a co							
.O. Box 6	The law requires that the death certifica ite has been signed by the attending ph bage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death	B Ectopic pregnancy Dother (specify)	,		23d. Date of o	lelivery Day Year	
rds, P	quires that n signed build be det		Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying cause giv	en in Part I.		Be. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown		
		Completed						24a. Was ar autops perform 1 Yes 2	y prior t ned? death	autopsy findings available o completion of cause of ?	
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 T S D (2 )	Oth		ath (Check only one			
o i	ding Ph J. After th funeral	I	27. Manner of Death  1 Sanatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpat 28b. Time Injury	of 28c, Injury	y at	28d. Describe ho	nce 6 Other (S) w injury occurred	oecify)	
Divisi	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	reet and Number or , State)	Rural Route Number,						
	the Hospital or nin 24 hours afte the Funeral Dir npletely filled in	edical (	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1	ysician: To the best of miner: On the basis of example and manner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	e, and due to the caurred at the time, da	suse(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	To th Comp	Me	29b. Signature and fittle of certains	The same		29c. Licens	54004		ed. Date signed (Mo	_	
			30. Name and address of pers in who Dr. S. Khanna, 12			e, Print)		1502		Ø , ====	
	Sta Registi	_	31. Date filed (Month, Day, Year)	Registrar's	-	way, Laval	e, MD Z	1302			

		•	1 - For State Registrar	State o	of Ma	aryland / De	partme ertifica					giene No. 2	001	errendi errendi errendi	6.2
	Physici /Medic		1. Decedent's Name (First, Middle,		EV.	EL_		2. Date of Month					Days Mans		
Y	Examin		4e. Fecility Name (If not institution,				4b. Cit	y, Town, or	Location o	of Death		4c. Cour	nty of Deet	h	
			Northwest Hospi			the construction of the first		lallst	OWN	24 Hre	0 Data of Bird		timor		
	Funeral Director		5. Social Security Number 183–12–6990	5.Sex 1 [x]M 2 □ F	7. Age	e (In yrs. last birtho Yrs	Month		Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Biri	hplece <i>(State or Foruntry)</i> nsylvania	eign
			Usual Residence of Decedent		, ,						Dec. 10	0, 192.	J ren	nsyrvania	
	nylanc how		10a. State 10b. County			10c. City, Town o	r Location							10d. Inside City Lin	
	Ba-1 s	cto	Maryland Carrol	L		Sykesvi	11e						1 □ Yes 2 ☑ No		
	or 24	Director	10e. Street and Number					10f. Zip Code					log. Citizen of What Country?		
	e 23a	rai	2126 Carroll Da	Le Rd.	odost I	Ever in LLC		1784	ionania Oriv	ain? (Sna		Inited		es rican Indian,	
	fter d	E E	11. Marital Status  1 ☐ Never Married 2 ★ Marrie	Armed F	orces?	10			n, Mexican	, Puerto I	cify Yes or No- Rican, etc.)	В	lack, White		
036	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve lates:	WWII	1 🗌 Yes	2 🔀 No	Specify:			Spec	city: Wh	ite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itame 23e or 28e-f show tha Marical Examinar must be millied at	Completed by Funeral	15. Decedent's	Education grade completed)		16a. D	ecedent's Us live kind of the DO NOT	sual Occupa	ation Juring most	t of worki	ng	16b. Kind of	Business/	Industry	
2	han han	щ	Elementary/Secondary (0-12)	College (	1-4or 5	+)					i	Dotas 1		T	
N	Hygie Hygie ther t	ပိ	12th 17. Father's Name (First, Middle, L	ast)		Pre	sident	Car-			(First, Middle,			Industry	
and	d be i	To Be	John E. Nevel						Berth						
37	shoul nd Me mari	F	19a. Informant's Name/Relationsh	p (Type, Print)	ype, Print) 19b. Mailin-						I Route Numbe	r, City or Tow	m, State, Z	Zip Code)	
	alth a		Barbara Nevel (V	Tife)		212	6 Carr	o11 D	ale R	kd. S	ykesvi <sub>l</sub>	le. MD	2178	34	
ore,	of He of Her		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 Demoval from	State	20b. Place of D cemetery,	sposition (A	ame of other plac	θ)	D	ate	20c. Locatio	n - City or	Town, State	
Ĕ	Pag ment ant: }		`4 □Donation 5 □Other (Sp		State	Garrison	n Fore	st Ve	t. Çe	m 1/	27/2004	Owing	s Mil	lls, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itame 23a or 28a-1 show any injury or other traumatic event, the Maricial Examination and once.		21. Signature of Funaral Service L	censes /	7						ier-Que Rd. Win			Director:	3
			23a. Part1. Enter the disease, or o	omplications that	caused	the death. Do not							110 2	Approximate Interval Between	
	Physician												Onset and Death		
	/Medical		resulting in death)	a. Due to	(or as	a consequence of)									
48	Examiner		Sequentially list conditions.	Ų			NON	14							
Ш.,	sit ad	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as	a consequence of)							İ		
-	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as	a consequence of)						<del></del>			
760,	sician buria	caiE											}		
89	g phy as the			0.											
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou		of pregnancy 2 Petal death	3 □Ectopic	oregnancy			23d. Date of delivery				
<u>.</u> Ш	e deal he att	sicia	in the past 12 months?  1  Yes 2 No		nant at	time of death	5 Other					'	Month	Day Year	
P. O.	d by 1	Phy	9 ☐ Unknown  Part II. Other significant condition	S contributing to a	loath h	at not regulting in th	a underhini	021100 01111	on in Part I		23e Did to	hacco use co	ostribute to	the cause of death	2
ds,	signe d be c	b	Partiti. Other significant condition	is contributing to c	ioatii oi	at not resulting in th	ie drideriyin	Cause give	minirani.		1 □ Y	./		obably 4 Unkn	
Ö	w requir been si should	Completed													
Re	he lav	du				· · · · · · · · · · · · · · · · · · ·					24a. Was a autop: perfor	sy med2		topsy findings avail- completion of cause	
Vital Records,	ificate	e C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only or	2 No	1 ☐ Yes	2 No	
	Physician: r this certifica ral director, I	To B	examiner? 1 Yes 2 No	Hospital:	Inpatie	nt 2 ER/Outpa	tient 3 🗆	Othe	200		ne 5 Resid		ther (Spec	cify)	
0	ng Ph ter th neral		27. Manwer of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mor	of Inju			28c. Injury	at		8d. Describe h				
Sio	Mttendir death. ctor: Af y the fu	atic	2 ☐ Accident investig	ation			М	10	Yes 2 □f	No					
Division of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could n 4 Homicide determin	200. Flau	e of Inju	ury - At home, larm c. (Specify)	, street, fact	ory, office		2	28f. Location (S City or Tow	treet and Nur n, State)	mber or Ru	ral Route Number,	
	spital ours a seral I		29a. Certifier 1 Certifying	Physicien: To th	e best o	of my knowledge, o	eath occurre	d at the tim	e date an	d place, a	and due to the c	ause(s) and	manner as	stated	
	Hos     Z4 h     Fur     Fur     Ietely	edicai	(Check only 2   Medical E	xaminer: On the t	asis of	examination and/o	r investigati	on, in my op	oinion, deat	th occurre	ed at the time, o	ate and place	e, and due	to the cause(s)	
	To th within To th	Me	29b. Signature and title of contifier	1 . 1 5	4.	^	2	9c. License	number	20	2	29d. Date sign	ned (Month	n, Day, Year)	
	110-		· 109)	Lucia	in			D	4410	US	J	BNUAL	ry v	2,2004	
	TIVA		30. Name and address of person v	no completed cau	se of d	eath (Item 23a) (Ty			11110	H	5401	Old Cou	IRT RO	21133	
			21 Data filed (Mark Day Vari	, Imp		1 4	1)			4	RANDI	9LLSTON	UN, MI	2/133	
	Sta Registr		31. Date filed (Morlth, Day, Year)	3 2004	registra	ar's Signature	1								
DH	MH 17 Rev 1/2		סחוז ג	3 ZUUT	J. S.	THE J.	A CONTRACTOR	W.							
						ORIG	INAL								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** VERNON 23,2004 JANUARY 8:55a<sup>M</sup> NELSON /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner HOLY CROSS REHABILITATION CTR BURTONSVILLE
Under 1 Year If Under 24 Hrs. MONTGOMERY 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1₽M 2□F Days Hours Min. Months 524-32-1771 Director 74 OCTOBER 6.1929 COLORADO Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 √Yes 2 No COLUMBIA MD HOWARD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5037 BROKEN OAK LANE 21044 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 ☐ Never Married 2X Married "natural", or 1 ☐ Yes 2 ☑ No Specify: Completed by BLACK 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 ANALYST US GOVERNMENT and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES GUY NELSON VIRGIE HILDA MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 ts STACY NELSON - DAUGHTER 5507 MISTIC COURT, COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 - 2 9 -20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. MD NATIONAL CEMETERY 2004 LAUREL, MARYLAND 21. Signature of Funeral Service Licensea 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. 20001 23a. Pert1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed **burial-transit** resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 Tes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25348 JANUARY 29, 2004 main 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARCIA P. GOLDMARK - 11906 DARNESTOWN RD., SUITE G N. POTOMAC, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 Registrar

			T = For State Registrar	State of Marylan	d / Depa		f Health and	d Mental Hyg	giene Reg. No. 200	4 04464	
	Physici	an	Decedent's Name (First, Middle, Last     Glen Faust	0sborne				2. Date of Dea Month	ath  y 1, 2004	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give 6225 Masons Sprin	street and number)			n, or Location of De		4c. County of D	eath	
	Funeral Director		5. Social Security Number  230–30–1835  Usual Residence of Decedent	7. Age (In yrs. 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da		in. 8. Date of Birt (Month, Day AUG 18,	v. Year)	Birthplace (State or Foreign Country) IRGINIA	
	Ba-f show	ctor	10a. State 10b. County  MARYLAND CHARLES		y, Town or Lo	cation IARBURY				10d. Inside City Limits 1 ☐ Yes 2 ☒No	
	3a or 2	i Dire	10e. Street and Number 6225 MASONS SPRII		10f. Zip Coo	<sup>le</sup> 20640			p. Citizen of What Country?  UNITED STATES		
1215-0036	perfinit. rages I and a should be lied within 7.2 flouts after death with the waryan Depertment of Health and Mental Hygiene. Important: if them 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☒ No Specify:			- 14. Race - A	merican Indian, /hite, etc.	
21215-0036	willing 7.5 mg ene. than "netur ne Medical	ompleted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation te completed) College (1-4or 5+)	(Give	DO NOT use re	ne during most of tired)	working	16b. Kind of Busine	ss/Industry	
Maryland 2	Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Last) ROBERT PRESTON OS	SBORNE	1	18. Mother's Name (First, Middle, M			-	COMP AN I	
Mar	trauma		19a. Informant's Name/Relationship (7) SHEILAH D. BOWERS		-	-			or, City or Town, State	a, <i>Zip Cod</i> a) LAND 20640	
Baltimore,	lent of Heal nt: If Item 2 ry or other		20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,	20b. P	lace of Dispo emetery, crer	esition (Name or matory or other EEMATORY	place) FE	BRUARY 2004	20c. Location - City WALDORF,	or Town, State	
Balti	Deportm Deportm Importa any inju		21 Signature of Furneral Service Licens		22	2. Name and Ad	Idress of Facility	HUNTT FUNI	ERAL HOME YLAND 2060	)4	
F	hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death one cause on each line.			dying, such as card	liac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
1760,		ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq  b. Due to (or as a conseq  c. Due to (or as a conseq  d.	uence of):						
P.O. Box 68	e attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	Ideath 3□	Ectopic pregna			23d. Date of Month	delivery Day Year	
ords, P.	ine law tequires in at the state of the stat	þ	Part II. Other significant conditions co		tobacco use contribute to the cause of death?  \$\sigma s = 2 \sum No 3 \sum Probably 4 \sum Unknown						
	ate has page 2	Completed				- autop perfor	4a. Was an autopsy available prior to completion of cause of performed?  □ Yes 2 Stool 1 □ Yes 2 Stool				
VII.	riysicien: The rithis certificate har al director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Other	Death (Check only or	ne) lence 6 □Other(S	(nacify)	
ion of	fter th		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. l	njury at Work?		ow injury occurred	рөспу)	
Divis	vithin 24 hours effer death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			City or Tow	m, State)	Rural Route Number,		
	o nosp 24 hou o Funei detely fil	edical	29a. Certifier 1 <del>TC</del> ertifying Phy (Check only 2 Medicai Exam one)	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death tion and/or in	n occurred at the vestigation, in m	e time, date and pla ny opinion, death o	ice, and due to the occurred at the time, o	cause(s) and manner date and place, and c	as stated. due to the cause(s)	
1	withir To th	Me	29b. Signature and title of certifier	~ m			ense number	1	29d. Date signed (Mo	onth, Day, Year)	
B	2			ompleted cause of death (Iten  NOTE S  S  OD 4  OD 4  OD 4  OD 5  OD 6  OD 7	23a) (Type,				DAS CLI	NOW MO 2073	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 03 2	32. Sgistrar's Signa	ture A	perte		,	1	,	

		State of Maryland / Department of Health and I  Certificate of Death	Mental Hygiene	01.1.66									
	Dhusisian	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Dey Year	3. Time of Death									
	Physiciar /Medica	TARINS AUGUSTINE PACHETO	JAN. 28, 2004	3:25 AM									
	Examine	4a Facility Neme (If not institution, give street and number)  4b. City, Town, or I	Location of Death 4c. County of Death										
		CUPPETT & WEEKS NURSING HOME  OAKLAND  5. Social Security Number  6. Sex  7. Age (In yrs. last hirthday)  If Under 1 Year   If Under 24 Hrs.	GARRETT										
	Funeral Director	5. Social Security Number 553-20-6238  6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 1 Vrs. 7 Age (In yrs. last birthday) 1 Vrs. 1 Months Days Hours Min.	8. Date of Birth (Month, Day, Year) JAN 17, 1925 CA 9. Birthp Coun	lace (State or Foreign try)									
		Usual Residence of Decedent	JAN 17, 1923 CA										
	how I	10a. State 10b. County 10c. City, Town or Location	1	0d. Inside City Limits									
	e Mai	MD GARRETT OAKLAND		1∭Yes 2□No									
	計 す。20 20 20 20 20 20 20 20 20 20 20 20 20 2	10e. Street and Number 10f. Zip Code	10g. Citizen of What Coun	try?									
	within 72 hours aftar death with the Maryland ene. than "natural; or items 23a or 28a-f show the Medical Examiner must be notified at home and the foundaries of the European Director.	623 S. THIRD STREET 21550	USA										
	ar de	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexicen, Puerlo	pecify Yes or No- o Rican, etc.) 14. Race - Americ Black, White, o										
36	urs aft	If Yes, Give 1 LAYes 2 □ No Specify: MF	XICAN Specify: MEX	KICAN									
21215-0036	2 hou	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Inc										
215	led within 72 horygiene. Ner than "netura It, the Medical I	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	king	,									
21	d with	8 RESTAURANT OWNER	FOOD SERVIC	CE									
pu	be filed tal Hygin d other event, to	17. Father's Name (First, Middle, Last)	ne (First, Middle, Maiden Sumame)										
yla	Mental Mental Merked o	JESUS PACHECO ROSARIO											
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To ORE Commissed by Eumaral Director	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru  101. IIA TERMINATION DEPOSITION DEP		Code)									
	1 and Health em 27 Ither tr	KAREN FRIEND - PERSONAL REP. 121 WATERWHEEL ROAD  20a. Method of Disposition   20b. Place of Disposition (Neme of	OAKLAND, MD 21550  Date 20c. Location - City or To	um State									
õ	Pages nent of I nt: If ite	1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place)											
Baltimore,	pemit. Pages Department of Important: If it any Injury or once.	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Nama and Address of Facility	1/31/04 MORGANTOWN,	WV									
ä	permit. F Departme Importan any Injur		P.O. BOX 243 E - OAKLAND, MD 2155	0									
		- former / / fulls	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate										
	Physician	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death											
4	Medical	Immediate Cause (Final disease or condition a pneumonia 5 days											
	Examiner	disease or condition resulting in death)  a. pneumonia  Due to (or as a consequence of):		days									
-		Hx of cerebrovascular acciden	nt	yrs									
	physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):											
68760,	be ax cian burial	cause. Enter Underlying Cause. Enter Underlying Cause. Chief Underlying Cause.											
287		that initiated events resulting in death) Last  Due to (or as a consequence of):											
Box	atter after L	Dod II Other standillow and title and and and and and and and and and and											
P.O.	0 0 2 4	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobacco use contribute to										
	as that igned b		TO THE ZONO SOFTOD	ably Marionii									
Records,				re eutopsy findings ilable prior to									
၁၁	aw Is b		сол	npletion of cause leeth?									
Ä	Tha la		1 □ Yes 2 No 1 □	Yes 2□ No									
Vital	certificata rector. pa	25. Was cese referred to medical 26. Place of Deat	th (Check only one)										
of V	S 5 5	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify	)									
	B 9 6 E	27. Manner of Death 1 SNatural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Injury at Work?	28d. Describe how injury occurred										
Sio	Attending or death.  ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not be	2011	10 11 11									
Division	tal or Attending P rs after death. In Director: After t ad in by the funers Certification;	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural City or Town, State)	Houte Number,									
_	ours fillad	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place,	and due to the cause(s) and manner as sta	ated									
	he Hospi in 24 hou he Funer pletaly fill	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occur and manner stated.	red at the time, date and place, and due to	the cause(s)									
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completaly filled in by the fur Medical Certification	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, E	Day, Yeer)									
		D30035	01-28-2004										
ļ	14118	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	l '	Donald R. Richter, M.D. 1533 Memorial Drive	Oakland. MD 2155	0									
	State	31. Date filed (Month, Day, Year)  JAN 3 0 2004  32. Megistrar's Signature	,										
	Registrar	JOHN DU LOUT LOUIS IN THE PROPERTY B											

DHMH 16 Rev 6/95

ORIGINAL

			1 - For State Registrar	State of Marylan	•	nt of Health and te of Death	Re	g. No. 200	- Company 6
	Dhycici	an	Decedent's Name (First, Middle, Last	)			2. Date of Death Month	n Day Ye <i>a</i> r	3. Time of Death
	Physici /Medio		STEPHEN J. PURYEA	R			JANUARY	28 2004	7:00 P M
7	Examin		4a. Facility Name (If not institution, give		4b. Cit	y, Town, or Location of D	eath	4c. County of Dea	th
			Genesis Elderca	ce		LaPlata		Charles	
	Funeral		5. Social Security Number 6. Se		Month	er 1 Year If Under 24 I s Days Hours N	Hrs. 8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign puntry)
п	Director		578-24-9183	<sup>™ 2□ F</sup> 95	Yrs.		July 30		th Carolina
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 Cih	, Town or Location				Table to the City I to the
	aryla sho	_		Wald					10d. Inside City Limits
	Ba-f	cto	4	Wald					1 ☐ Yes 2X No
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "dical Exaudhar cust be notified at	Funeral Director	10e. Street and Number			Lip Code	10	g. Citizen of What Co	ountry?
	23a	a	10395 Berry Road			0603		USA	
	e E	ne l	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whi	
36	or It	F.	1 Never Married 2 Married	11 <b>⊘</b> Yes 2 □ No If Yes, Give		2 No Specify:		Specify: W	_
21215-0036	ural',	d by	3X Widowed 4 □ Divorced	Year or Dates:					
<u>7</u>	nat nat	Completed	15. Decedent's Edu (Specify only highest grad	lcation le completed)	16a. Decedent's Us (Give kind of	sual Occupation work done during most of use retired)	working 1	6b. Kind of Business	/Industry
2	Aithin Bar.	μ	Elementary/Secondary (0-12)	College (1-4or 5+)					
	a filed withir Il Hygiene. other than vent, the M		12		Carpente			onstructi	On
Ē	tal H d of	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle, M	·	
yla	2 should be and Mental Is marked o aumatic eve	ျ	James Thomas Pury	2.40 4.44			Chandler		
Maryland			19a. Informant's Name/Relationship (T)			ss (Street and Number of			· · · · · · · · · · · · · · · · · · ·
	1 and Health em 27 ther tr		Richard Puryear (S			vis Mill Way			
ore	00		20a. Method of Disposition  1	Removal from State	lace of Disposition (Nemetery, crematory of	ame of other place)	Date 2	0c. Location - City or	Town, State
Baltimore,	Pa Int:		'4 □Donation 5 □ Other (Specify)		nity Memor	cial Cem 2-2	2-04	Waldorf,	ΜĎ
alt	permit. Departr Importa any inju		21. Signature of Fur ral Service Licens			and Address of Facility	Eberwein F		· Print
8	89 = 29		Echu H	210-	4433	White Pls. I			
			23a Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the death					Approximate Interval Between
	Pnysician		Immediate Cause (Final	E TO CAROLI	Sun	ANCONO	1211	1.1.10	Onset and Death
	/Medical	0	disease or condition resulting in death)	a. Due to (or as a consequ	ience of).	17100000	nugnis	112000.	XMONTH
н	Examiner			Dallanie	an Am	Luscie	DOSET.		& Welma).
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	ience of):	plac 3000	-0.0-0,		7
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury						
_,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	xa	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):				
8760,	sicial buri	lical	L.						
687	icate phy: s the	ğ		0					
	death certifica attending ph I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnal	ncv			23d. Date of de	in can c
Вох	atter for u	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3□Ectopic			Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	satir.	эрөспу/	· · · · · · · · · · · · · · · · · · ·		
٥	that the death cer ed by the attendin detached for use		Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	cause given in Part I	23e. Did toba	acco use contribute to	the cause of death?
JS,	signe signe	ρ		ouddo givori ii v aici.		2 □ No 3 □ Pr	14		
Records,	w requires that been signed b should be deta	Completed					- 1016	2010 0011	ocabi) Commonii
ec	law asb	g					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<b>E</b>		ĕ					perform 1 □ Yes 2	ed? death? No 1 ☐ Yes	
of Vital	Phyaician: The law this certificate has b ral director, page 2 s	Be (	25. Was case referred to medical examiner?	W-1-2-5-1		28. Place of I	Death (Check only one	)	
<b>&gt;</b>	Physic this ce al dire	၉	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ 1	ER/Outpatient 3 []	OOA Other: Nursin	g Home 5 ☐ Residen	ice 6 Other (Spe	city)
0	ding Ph J. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
Division	Ntendin death. ctor: Afi y the fur	atio	Natural 5 Pending 2 Accident investigation	(Month, Bay Your)	M	1 Yes 2 No			
Vis	Atte acto by th	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho		ery, office		eet and Number or Ru	ıral Route Number,
Ö	s afte	Certification:	- Unomicide	building, etc. (Specify	7		City or Town,	Jidle)	
	spit hour: nera / fille		29a. Certifier Certifying Phy	sician: To the best of my know	wledge, death occurre	d at the time, date and pla	ace, and due to the cau	use(s) and manner as	stated.
	A HC	Medical	(Check only 2 Medicel Exami	ner: On the basis of examinat and manner stated.	ion and/or investigation	n, in my opinion, death o	ccurred at the time, dat	e and place, and due	to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.	Me	29b. Signature and title of certifier	1 An	2	9c. License number	29	d. Date signed (Mont	h, Pay, Year)
	->-0		1 Jana 1	h All	T	771162	4	1/00	104
^			30. Name and address of pelson who co	ompleted cause of death (Item	23a) (Time Print)	12000		1/67	/ ~ /
1	12.51		T G D C	AT 2	J. M. O	WALDER	r, mil	.2060	33
	Sta	to	31. Date filed (Month, Day, Year)	32. Redistrar's Signat	ture.	101100 610	11,1100		- 1
	Registr		FEB 0 3 2	004 Alegue	B. Docas	( )			

			Flease	State of Ma							-egible.	
		-	For State Registrar	State of Ivia	li ylaii	•	rtificate of		-	Reg. No.	2006	06468
			Decedent's Name (First, Middle, Last	1)	_				2. Date of De	ath		3. Time of Death
	edica	al -	Robert Jordan  4a. Facility Name (If not institution, give	Peel			4b. City. Town, o	r Location of Death	January		Year 2004 County of Deat	6:50 A <sup>M</sup>
Exa	mine		Frederick Memorial				Frederic				rederio	
Fune	ral		5. Social Security Number 6. Se	7. Age	(in yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	h		hplace (State or Foreign
Direct	or		165-14-2539 Usual Residence of Decedent	XM 2□F 86		Yrs.		110010	July 5,	191	7 Penn	sylvania
be filed within 72 hours atter death with the Maryland lall Hyglene. d other than "netural", or items 23e or 28e-f ehow event, the Modice Exertiter for the first land.		_	10a. State 10b. County			y, Town or Lo	ecation					10d. Inside City Limits 1 1 Yes 2 □ No
he Mi		Director	Maryland Frederic	k	Fred	lerick	10f. Zip Code			10a Citia	en of What Co	
with a			6331 Mountaindale	Road			21702			•	ed Stat	
death		Funerai	11. Marital Status	12. Was Decedent B	ver in U	.S. 13.	Was Decedent of H				4. Race - Ame	erican Indian,
atter or Item		בֿ	1 Never Married 2 Married	Armed Forces? 1 [XYes 2 □ N If Yes, Give	lo 19	43	if Yes, specify Cuba 1 ☐ Yes 2 ဩ No	Specify:	o Hican, etc.)		Black, Whit	e, etc.
72 hours "natural",	:	d by	3 Widowed 4 Divorced	Year or Dates:	19	46					Specify: Whi	
be filed within 72 ho tal Hygiene. d other than "natu		Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kin	nd of Business	Industry (Industry
within and then then		E I	Elementary/Secondary (0-12)	College (1-4or 5	+)		istrative			II S	Govern	nment
Hygi other	2	BeC	17. Father's Name (First, Middle, Last)	н		Mumili	ISCIACIVE	18. Mother's Nan	ne (First, Middle,			IMETIC
		To B	Saxon W.	Peel				Alice	D.		Jordan	
S S E			19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or	Town, State, 2	Zip Code)
and and and and and and and and and and			Rose M. Peel /	wife_	1			dale Roa				and 21702
Des 1			20a. Method of Disposition 1 XBunial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	Place of Dispo cemetery, crea	osition (Name of matory or other plac		Date	20c. Loc	cation - City or	Town, State
Deficiency Pages Separation of mportant: If it			`4 □ Donation 5 □ Other (Specify		Res		Memoria.	1				Maryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny initiary or other tra	ouce		21. Signature of Funeral Service Licen:	S <del>80</del>			2. Name and Addre					
		-	23a. Part 1. Enter the disease, or comp	olications that caused	the deat						k, Mary	yland 21702 Approximate
Physici	an	ĺ	shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	e	1 310	Cali.	Insenler	) Die			Interval Between Onset and Death
/Medic	_		disease or condition resulting in death)	a. Duoto (or as a	a conseq	uence of):	Crixia	rnsenen	1 41/24	rse		sgro
Examin			Sequentially list conditions	b								
p ts		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseq	uence of):						
xecute and I-tran		Examiner	that initiated events resulting in death) Last	cDue to (or as a	a conseq	uence of):						- <u></u>
The law requires that the death certificate be executed ate has been signed by the attending physician and mane 2 should be detached for use as the burial-transit		calE		·		,						
ficate g phys				d								
n certi		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			⊒Ectopic pregnancy	,		2	3d. Date of del	livery
death death and for		Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)				Month	Day Year
at the d by the		Phy	9 Unknown						00. 0:11	.1		the court of death 0
res th		þ	Part II. Other significant conditions co	ontributing to death bu	it not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did t		1	o the cause of death?
w requires been sign		Completed									1	
has l		шb		-					24a. Was autop	osy	prior to death?	topsy findings available completion of cause of
len: Tr len: Tr intificate		e Co	25. Was case referred to medical							2 No	1 Tes	2 No
VIII sicle		To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 <b>X</b>	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing H	ith (Uneck only o		□Other /Sne	cita)
9 Phy gerthis			27. Manner of Death	28a. Date of Injur (Month, Da)	y	28b. Time o		y at	28d. Describe			ony,
anding ath. or: Afte		atio	1 Natural 5 Pending investigation		1047	mijury		Yes 2 □No				
or Atter		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At h	ome, farm, st	reet, factory, office		28f. Location ( City or To			ural Route Number,
UNISION OF VITAINECONAS, P.O. BOX 001  To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Directors After this certificate has been signed by the attending physmometals think in by the timeral director name 2 should be detached for use as the		edical C	29a. Certifier Certifying Ph (Check only one) Medical Exam	ysician: To the best of hiner: On the basis of and manner sta	examina	owledge, deat ation and/or in	th occurred at the timestigation, in my control	me, date and place pinion, death occu	and due to the arred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
Fo the		Mec	29b. Signature and little of pertifier	12/1 /2	7		29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
- > - C			> Xihll 1	Karten	un.	~/	D-15	97/	and the second	1/2	7/04	
10,			30. Name and address of person who	completed dause of d	eath (Iter	n 23a) (Type,		/			1	
12			Robert L. Kaufman				rederick,	Marylan	d 21701			
Per	Stat		31. Date filed (Month, Day, Year)	32. Registe	r's Signa	ature M.	Joele					

		1	For State Registrar	State of M	laryland /		artment			nd Me		giene 20	04	0446
	hysicia /Medic	an al	1. Decedent's Name (First, Middle,	1N Pt	ILLI	P	)				Date of Dea	ath Pay 25	Year	3. Time of Death
+ Fu	xamin ineral		Howard Count 6 5. Social Security Number 6	y Genera	age (In yrs. last t	oirthday) Yrs.	4b. City,  If Under  Months	C	If Under 24	1 Hrs. 8	Date of Birth (Month, Day	h y, Year)	9. Birthpli Count	ace (State or Foreign ry)
	ector		Usual Residence of Decedent 10a. State 10b. County		76		cation	l		J	une 30	0, 1927	Georg	d. Inside City Limits
Z I Z I D-UUSO ed within 72 hours after dea ygiene.	ner then "natural", or items 23a or 28e-f show it, the Medical Examinar must be notified at	Completed by Funeral Direc	Maryland Howard  10e. Street and Number  17314 Pink Dog  11. Marital Status  1 Never Mamed 2 Marned  XXWidowed 4 Divorced  15. Decedent's  (Specify only highest  Elementary/Secondary (0-12)	12. Was Deceder Armed Forces of 1   Yes 2   1   Yes, Give Year or Dates    Education grade completed)  College (1-40)	at Ever in U.S. ?? ]No ::	13. Ta. Dece	1 ☐ Yes 2 dent's Usua kind of wor DO NOT us	21 lent of His tify Cubar XXNo al Occupa rk done di se retired)	Specify: tion uring most o	of working	y Yes or No- can, etc.)	Specify:	Stat - America c, White, e  Wasiness/Ind	ces an Indian, ttc. Thite
Ore, Maryiand les 1 and 2 should be fill of Health and Mental Hy	If item 27 is marked otl or other traumatic even	To Be	17. Father's Name (First, Middle, La  Eros Medlock  19a. Informant's Name/Relationship  Lona A. Sauro,  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3	o (Type, Print) daughter	20b. Place	1731	4 Pin	(Street a	Les1	Lie M or Aural F	. Edwa	Maiden Sumame  ards  ar, City or Town, S  Airy, N  20c. Location - 0	State, Zip (	and 2177
Department of	Importent: the same injury of same i		*4 Donation 5 Other (Spe 21. Signature of Funeral Service U	cerify)	Lewins	8	East	d Address	s of Facility gevill	Stau Le B1	ffer F vd. Mt		Homes	ginia , P.A. land21771
/Me Exa	nysicien and edical transit	cal Examiner	23a. Fant1. Enter the disease, or construction. Shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last	b. Due to (or a	is a consequence as a c	e of):	>	4	i, such as ca			rest,	7	Approximate Interval Between Onset and Death 2 TUVES
BOX 68	attending pl for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ne of pregnancy 2  Fetal dea at time of death		Ectopic pro					23d. Date Mon		y Day Year
OrdS, P.	been signed by the should be detached	by	Part II. Other significant condition  CHRUNC  CUN DEST	OBSTRUC	TIVE P		nderlying co		O IS E	ME	1/Z/Y		3 🗌 Proba	ably 4 Unknown
VITAI MECORDS, sicien: The law requires t	tificate has tor, page 2 s	Be Completed	25. Was case referred to medical	ALC ME	0 101 1	M		~ <i>C</i>	26. Place o	of Death (	24a. Was autop perfor 1 Yes	rmed? de 2 No 1	rior to com	sy findings avaitable pletion of cause of
n Of ng Phys	I Director: After this certificate has d in by the funeral director, page 2	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	28a. Date of in (Month, Date of In (Month, Date of In (Month), Dat		Time o	M 2	8c. Injury Work 1 🗆 Y	r. 4 □ Nurs	ing Home 280	5 🗍 Resid	dence 6 Other	d	
To the Haspite within 24 hours	To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  29b. Signature and trile of certifier	Physicien: To the best ceminer: On the basis and manner	of examination i	ge, deat and/or in	vestigation,	at the time, in my op	inion, death	ptace, and occurred	at the time, o	cause(s) and mar date and place, a 29d. Date signed	nd due to	the cause(s)
10			30. Name and address of person w	ho completed cause of	death (Item 23a	JVV Dype.	PH G	7	777 SINT	09				0 21738
-	Sta Registr	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1	hory	(L)	30 (18	-10			1'\'	20100

DHMH 17 Rev 1/2001

ysici:		Registrar  1. Decedent's Name (First, Middle, La	st)	Ce	rtificate of	Death	2. Date of De		- 004	3. Time of Death
Medic	-	Harold	Parker				Month O1	Day 11	2004	12:37p
kamin	_	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Deat	th	4c. Co	unty of Deeth	
¥		Washington Adven			Takoma				ontgome	ry
neral		5. Social Security Number 6. S	Sex 7. Age (	(In yrs. last birthday)	Months Days			th y, Year)	9. Birthp Cour	lace (State or Fore
ector		243-08-3585 Usuel Residence of Decedent		70 Yrs.			March	13, 19	33Rocky	Mount, N
4		10a. State 10b. County	i	10c. City, Town or Lo	ocation				1	0d. Inside City Lim
tities	ctor	Maryland Montg	gomery	Silver	Spring					1X Yes 2□
any injury or other treumatic event, its Medical Examiner must be notified at pose.	Funeral Director	10e. Street and Number			10f. Zip Code			-	of What Cour	ntry?
	ra	9101 Second Aver		1 110	2091				U.S.A.	
THE STREET	nue	11. Marital Status 1    Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 📉 No		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14.	Race - Americ Black, White,	
	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Sp	ecify: Blac	:k
	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind	of Business/Inc	dustry
	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo	rking	Nor	ne	
	Con	Spec. Ed			None	· · · · · · · · · · · · · · · · · · ·				
	Be	17. Father's Name (First, Middle, Last,	)				me (First, Middle,	Maiden Sui	mame)	
	스	Robert E. Parker	T Orien)	201 11 10		Audalen				
		19a. Informant's Name/Relationship ( Robyn Pearson/MRD	DA Case	429	ng Address (Street O Street	. N.W.		er, City or To	own, State, Zip	Code)
1	- 7	20a. Method of Disposition	Manager	20b. Place of Dispo	nington,		O1 Date	20c. Locati	ion - City or To	wn. State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ * 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		matory or other pla		12 2007		,	
		21. Signature of Funeral Service Licer		Ft. Linco	2. Name and Addre	ess of Facility W	22-2004 H Bacon	Brade	nsburg,	, Maryla
any onc		Manda C.	Bacon C	1361	3447 14th	St. N.	W. Wash.	. D.C.	. 20010	e, Inc.
9		23a. Part1. Enter the disease, or com shock, or heart failure. List only								Approximate
an		Immediate Cause (Final								Onset and Death
al		disease or condition resulting in death)		price of):	SHOCK	<del> </del>				4 day
er			12 5 1	-	1.00					
		Conventially list conditions	h KENAL	- FAIL	LURE					4 day
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	CONSEQUENCE OF).	ur E					4 day
1000	caminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. DEC	синачивнов vt). В 1-Т и 5		AL AR	LEA I	NFE	TE	4 day 3 Mont
חנומו-ונמנופוו	I Examiner	Cause (Disease or injury	c. DEC	Consequence of):		AL AR	LEA Z	NFE	TE	4 day
ille pullar li arisii	a	that initiated events	c. DEC	син <b>э</b> чивпов vI). В 1-Т 4-5		AL AR	LEA Z	NFE	TE)	3 Mont
פס בס נווס טעוומריוומרוסא	a	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d	Consequence of):		AL AR	REA Z			
	a	Lause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 moonts?	c. Due to (or as a domination of the control of th	consequence of):  pregnancy Fetal death 3 [	SACR		LEA I		Date of delive	
	a	Cause (Disease or injury that infiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	c. Due to (or as a d	consequence of):  pregnancy Fetal death 3 [	SACR		LEA Z		Date of delive	ry
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. Due to (or as a of the control of	pregnancy Fetal death 3 [me of death 5 [	SACR  Ectopic pregnanc Other (specify)	у		23d.	Date of delive Month	ry Day Year
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Moo	c. Due to (or as a of the control of	pregnancy Fetal death 3 [me of death 5 [	SACR  Ectopic pregnanc Other (specify)	у	23e. Did t	23d.	Date of delive Month	ry Day Year e cause of death?
מוניסטום כש מפומכוושם וכו חשם מס ווונ	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Moo	c. Due to (or as a of the control of	pregnancy Fetal death 3 [me of death 5 [	SACR  Ectopic pregnanc Other (specify)	у	23e. Did t	23d.  obacco use o	Date of delive Month  contribute to th  3   Probi	ry Day Year e cause of death? ably 4 ∐Unkno
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Moo	c. Due to (or as a of the control of	pregnancy Fetal death 3 [me of death 5 [	SACR  Ectopic pregnanc Other (specify)	у	23a. Did to 1 24a. Was autop perfo	23d.  bbacco use of the second	Date of delive Month  contribute to th  3 Probe  4b. Were autoprior to condeath?	ry Day Year e cause of death? abiy 4 Unknoosy findings availa
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 St. Was decedent pregnant in the past 12 mont	c. Due to (or as a of the control of	pregnancy Fetal death 3 [me of death 5 [	SACR  Ectopic pregnanc Other (specify)	y ven in Part I.	23a. Did to 1 1 24a. Was autop perfo	23d.  obacco use of section and section an	Date of delive Month  contribute to th  3 Probi	ry Day Year e cause of death? abiy 4 Unknoosy findings availa
	Be Completed by Physician/Medical	Cause (Disease or injury that infiliated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown  Part II. Other significant conditions of	c. Due to (or as a of the control of	pregnancy Fetal death of death for the unit resulting in the u	SACR  Dectopic pregnanc Other (specify)	y ven in Part I. 26. Place of De:	23a. Did to 1 \( \text{1} \) 24a. Was autor performed to Yes ath (Check only of	23d.  cobacco use of the second secon	Date of delive Month  contribute to th  o 3   Prob.  4b. Were autor prior to con death? 1   Yes	ry Day Year e cause of death? ably 4 Unknot begin by findings availant of cause 2 No
	To Be Completed by Physician/Medical	Lause (Disease of injury that infilated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No  25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death	c. Due to (or as a of the contributing to death but the contribution of the contributi	pregnancy Fetal death 5 not resulting in the u	SACR  Ectopic pregnanc Other (specify)  Inderlying cause grid	y ven in Part I. 26. Place of Dec ner: 4 \( \subsection \text{ Nursing H} \)	23a. Did to 1 1 24a. Was autop perfo	23d.  obacco use of symmetry  rmed? 21 No	Date of delive Month  contribute to th  3 Probe  4b. Were autor prior to condeath? 1 Pes	ry Day Year e cause of death? ably 4 Unkno psy findings availa npletion of cause 2 No
	To Be Completed by Physician/Medical	Cause (Disease or injury that infiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a of Due to (or	pregnancy Fetal death 35 not resulting in the u	SACR DEctopic pregnanc Other (specify) _ Inderlying cause gr	y ven in Part I. 26. Place of Dec ner: 4 \( \subsection \text{ Nursing H} \)	23e. Did to 1 1 24a. Was autoperfo 1 29s ath (Check only of the chartest of th	23d.  obacco use of symmetry  rmed? 21 No	Date of delive Month  contribute to th  3 Probe  4b. Were autor prior to condeath? 1 Pes	ry Day Year e cause of death? ably 4 Unknot begin by findings availant of cause 2 No
	To Be Completed by Physician/Medical	Cause (Disease or injury that infitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions of the co	Due to (or as a complete to co	pregnancy Fetal death of death  of death  consequence of):  pregnancy Fetal death of death  solution  consequence of):  pregnancy Fetal death of death  solution  consequence of):	SACR    Ectopic pregnanc    Other (specify)     Inderlying cause grant    3    DOA    Inderlying cause grant    28c.    Injury    Mo    Mo    1	y ven in Part I.  26. Place of De: 10: 4 \( \) Nursing H ry al	23e. Did to 1 24a. Was autor perfo 1 Yes ath (Check only of dome 5 Resid 28d. Describe N	23d.  cobacco use of the second secon	Date of delive Month  contribute to th  o 3   Probi  4b. Were auto prior to con death?  1   Yes  Other (Specify	ry Day Year e cause of death? ably 4 Unkno psy findings availa npletion of cause
מון כם מפומרופת זכן חפם מפי וויפ	Certification; To Be Completed by Physician/Medical	Cause (Disease or injury that infiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a composite to the composi	pregnancy Fetal death not resulting in the u  2 ER/Outpatier  28b. Time of Injury  - At home, farm, str (Specify)	SACR  Ectopic pregnanc Other (specify)  Inderlying cause ground and all DOA  of 28c. injuny M  of 1  reet, factory, office	y y yen in Part I.  26. Place of Declar in Part I.  26. Place of Declar in Part I.  4 \( \text{Nursing H} \)  7 at the result in Part I.	23e. Did to 1 1 24a. Was autor performence of the control of the c	23d.  cobacco use of the second secon	Date of delive Month  contribute to th  3 Probi  4b. Were autor prior to con death? 1 Yes  Other (Specify) courred	Day Year e cause of death? ably 4 Unkno psy findings availa npletion of cause of 2 No  1 Route Number,
should be detached for use as the	Certification; To Be Completed by Physician/Medical	Cause (Disease or injury that infitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a composition of the best of	pregnancy Fetal death of death  consequence of):  pregnancy Fetal death of death  self-self-self-self-self-self-self-self-	SACR  Ectopic pregnanc Other (specify) Inderlying cause grant Sal DOA  of 28c. Inju Wo M 1  reet, factory, office	yen in Part I.  26. Place of Decrete: 4 Nursing Horses 2 No	23a. Did to  1 \( \text{1} \)  24a. Was autoporto 1 \( \text{Yes} \) ath (Check only of 28d. Describe to 28d. Describe to City or Tov	an sy rmed? 2 No ne) dence 6 now injury oc	Date of delive Month  contribute to th  o 3   Probi  4b. Were autoprior to condeath? 1   Yes  Other (Specify) courred	Py Day Year  e cause of death?  abily 4 Unkno  psy findings availa  ppletion of cause of  2 No  Route Number,
should be detached for use as the	To Be Completed by Physician/Medical	Cause   Disease or injury that infitated events resulting in death) Last	Due to (or as a composite to the composi	pregnancy Fetal death of death  consequence of):  pregnancy Fetal death of death  self-self-self-self-self-self-self-self-	SACR  Ectopic pregnanc Other (specify) _ Inderlying cause gring  and 3 DOA  f 28c. inju Wo M 1 _ reet, factory, office h occurred at the til vestigation, in my of	yen in Part I.  26. Place of De: ner: 4 \( \) Nursing F ry at rk? Yes 2 \( \) No me, date and place spinion, death occu	23a. Did to 1 24a. Was autor period 1 Yes ath (Check only of Resid 28d. Describe to 28f. Location (Solly or Tow a, and due to the urred at the time,	an an an an an an an an an an an an an a	Date of delive Month  contribute to th  o 3 Probi  4b. Were autor prior to con death? 1 Yes  Other (Specify courred  umber or Rural  d manner as stace, and due to	ny Day Year e cause of death? abily 4 Unkno posy findings availa npletion of cause 2 No () () () () () () () () () () () () ()
should be detached for use as the	Certification; To Be Completed by Physician/Medical	Cause   Disease or injury that infitated events resulting in death) Last	Due to (or as a control of the contr	pregnancy   Fetal death   3     me of death   5     not resulting in the u  2   ER/Outpatier   28b. Time of Injury   At home, farm, stress (Specify)  my knowledge, deat xamination and/or in ind.	SACR  Ectopic pregnanc Other (specify) _ Inderlying cause grinderlying grinderlying grinderlying cause grinderlying grind	y y yen in Part I.  26. Place of De: ner: 4 \( \text{Nursing F} \) vy at rk? Yes 2 \( \text{No} \) me, date and place spinion, death occurse number	23e. Did to 1 24a. Was autor perfor 1 Yes ath (Check only of 28d. Describe to 28f. Location (Solity or Tow a, and due to the aurred at the time,	an an an an an an an an an an an an an a	Date of delive Month  o 3 Probi  Ab. Were autoprior to condeath? 1 Yes  Other (Specify courred  d manner as stace, and due to	Pour Pour Pour Pour Pour Pour Pour Pour
completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Certification; To Be Completed by Physician/Medical	Cause   Disease or injury that infitated events resulting in death) Last	Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)  Due to (or as a composition of the basis of examples)	pregnancy   Fetal death 30   me of death 50   not resulting in the u  2   ER/Outpatier /ear)   28b. Time of Injury / At home, farm, str. (Specify)  my knowledge, deat xamination and/or ind.	Ectopic pregnanc Other (specify)  Inderlying cause gn  28c. Injun Wo M 1  reet, factory, office h occurred at the ti vestigation, in my office  29c. Licens D - 6	yen in Part I.  26. Place of De: ner: 4 \( \) Nursing F ry at rk? Yes 2 \( \) No me, date and place spinion, death occu	23e. Did to 1 24a. Was autor perfor 1 Yes ath (Check only of 28d. Describe to 28f. Location (Solity or Tow a, and due to the aurred at the time,	an an an an an an an an an an an an an a	Date of delive Month  contribute to th  o 3 Probi  4b. Were autor prior to con death? 1 Yes  Other (Specify courred  umber or Rural  d manner as stace, and due to	Day Year  e cause of death' abiy 4 Unknot be findings available findings available poly findings avail

	1	State of Maryland / Department of H		Reg	4 U U H	04471
Physicia /Medica Examina	in al -	Taciny Hamo (it not institute)	r Location of Death	2. Date of Death Month January	23, 200  4c. County of Death	1
Funeral Director		Bradford Oaks Clint 5. Social Security Number $6.8ex \\ 5.77-70-2926 \\ 1 \square M 2 \ F$ 7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth /Month, Day, Y 3 - 14 - 1	P 908 Sou	place (State or Foreign
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insportment: If Item 21 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exertment be notified at once.	rai Director	1 □ Never Married 2 □ Married  3 □ Method of Disposition  X Burial 2 □ Cremation 3 □ Removal from State  1 □ Yes 2 □ No  1 □ No  1 □	dispanic Origin? (Spean, Mexican, Puerto find Specify:  Dation during most of working file  18. Mother's Name Of Stand Number or Rura burn Courses of Facility  ery 1 - 3 least of Facility	ng 16  (First, Middle, Magechee 11  Route Number, Camp  ort - Camp  ort - Camp  ort - Camp	Sb. Kind of Business/ (OWN HOMEMAKE Aiden Sumame) Rice City or Town, State, Z Springs Oc. Location - City or	ican Indian, o, etc. 1 a c k ndustry n o m e ) r
State be executed hysician and hysician and hysician and the burial-transit	icai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on eachdine.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		n respiratory arres		Approximate Interval Between Onset and Death
it the death certificate by the attending phy tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death			23d. Date of del Month	Day Year
e law requires tha has been signed je 2 should be de	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr	ven in Part I.	1 ☐ Yes 24a. Was an autopsy perform	24b. Were au prior to death?	obably 4 Unknow utopsy findings availab completion of cause of
ysician: is certifica director,	Certification; To Be Co	27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 1 Injury 1 Natural 5 Pending (Month, Day Year)	ther: 4 Nursing Ho ury at ork? Yes 2 No	me 5 Residen Residen 28d. Describe how	nce 6 Other (Spendingly occurred	cify)
To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Medical Cer	by State and the distribution of sources.	opinion, death occurrence number	29	te and place, and due $d$ . Date signed (Mont $\mathcal{O}(-2\mathcal{G})$	h, Day, Year)
St. Regist	ate	30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	~ M 170	74/	Michae	L SIDAR

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 06672 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 24, 2004 1:00 p Daniel Vincent Patton /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince George's Hyattsville 4001 Madison Street Hydron 1 Year | Hours 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 20, 1 9. Birthplace (State or Foreign 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 □ F 1936 Washington, DC 67 577-46-1715 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. If a Madical Example maint be notified at once. 1 Nes 2 No Hyattsville Prince George's Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20781 4001 Madison Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Editor's Press Journeyman Folder Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Barbara Manul Daniel LeRoy Patton James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21740 10031 Beaver Creek Church Rd., Hagerstown, MD Deborah A. Lasick - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/29/2004 Brentwood, Maryland Fort Lincoln Cemetery \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, 21. Signature of Funeral Service Licensee Aganta 4739 Baltimore Ave., Hyattsville, MD vdette Jasch 23a. Part1. Enter the disease, or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arrhythmia /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, nding physician IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to þ Division of Vital Records. 1 X Yes 2 No 3 Probably 4 Unknown Non-Small Cell Lung Cancer Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hypertension autopsy performed? 1 ☐ Yes 2 X No certificate the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No 은 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Injury After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No М death. 2 Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certified January 28, 2004 D-25914H.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Brimmer, M.D., 12201 Plum Orchard Drive, Silver Spring, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 2 9 2004

Department of Health and Muttal Hygione.  Compartment of Health and Muttal Hygione.  Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be netified any injury or other traumatic event, the Medical Examiner must be netified.  To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last)  ARTHER LEE PRIDGEN  4a. Facility Name (If not institution, give s FOREST GLEN NURSIN  5. Social Security Number  241-32-7041  Usual Residence of Decedent  10a. State 10b. County  Md Prince Gec  11. Marital Status 1 Never Married 3 Widowed  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12) 6th  17. Father's Name (First, Middle, Last)  Walter Pridge	Street and number)  G HOME  7. Age (In yrs. last birthday)  78  10c. City, Town or Lo District  12. Was Decedent Ever in U.S. Amed Forces? 1   Yes 2   ENo If Yes, Give Year or Dates: action 2 completed)  College (1-4or 5+)	4b. City, Town, or Location of De  Silver Spring  If Under 1 Year If Under 24 H  Months Days Hours M.  Location  Heights  10f. Zip Code 20747  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put  1 Yes 2 No Specify:	JANUARY 16 ath  rs. 8. Date of Birth (Month, Day, Yea  March 2,	Day Year 6, 2004 4c. County of Death Montgmery ar) 9. Birth Cot 1925 Rock Citizen of What Cot ited Stat	nplace (State or Foreintry)  Y Mount,  10d. Inside City Limit  1
Department of Health and Mental Hygiene  Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be netified any injury or other traumatic event, the Medical Examiner must be netified any injury or other traumatic event, the Medical Examiner must be netified any injury or other traumatic event, the Medical Examiner must be netified and injury or other traumatic event, the Medical Examiner must be netified and injury or other traumatic event, the Medical Examiner must be netified and injury or other traumatic event, the Medical Examiner must be netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event, the Medical Examiner must be not the netified and injury or other traumatic event.	FOREST GLEN NURSIN  5. Social Security Number  241-32-7041  Usual Residence of Decedent  10a. State  10b. County  Md  Prince Gec  10e. Street and Number  2000 Harewood Rd.  11. Marital Status  1 Never Married  3 Widowed  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  6th  17. Father's Name (First, Middle, Last)  Walter Pridge	G HOME  7. Age (In yrs. last birthday) 78 Yrs.  10c. City, Town or Louder Corner of Service Se	Silver Spring  Silver Spring  If Under 1 Year If Under 24 H  Months Days Hours M  Location  Heights  10f. Zip Code 20747  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put  1 Yes 2 No Specify:	rs. 8. Date of Birth (Month, Day, Yea March 2,	4c. County of Death Montgmery ar) 9. Birth Coit 1925 Rock Citizen of What Cot ited Stat	nplace (State or Foreintry)  Y Mount,  10d. Inside City Limit  1
Department of Hailth and Mental Hygiene.  Department of Hailth and Mental Hygiene.  Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show and injury or other traumatic event, the Medical Examiner must be netified a pace.  To Be Completed by Funeral Director	5. Social Security Number  241-32-7041  Usual Residence of Decedent  10a. State  10b. County  Md  Prince Gec  10e. Street and Number  2000 Harewood Rd.  11. Marital Status  1 Never Married  3 Widowed  15. Decedent's Educ  (Specify only highest grade  Elementary/Secondary (0-12) 6th  17. Father's Name (First, Middle, Last)  Walter Pridge	7. Age (In yrs. last birthday) 78  Yrs.  10c. City, Town or Lo District  12. Was Decedent Ever in U.S. Amed Forces? 1   Yes   2   ENo If Yes, Give Year or Dates: 2 completed)  College (1-4or 5+)	Ocation Heights  10f. Zip Code 20747  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	March 2,	1925 Rock Citizen of What Cot ited Stat	xy Mount, 10d. Inside City Limit 1译Yes 2□N
Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be netified any injury or other traumatic event, the Medical Examiner must be netified.  To Be Completed by Funeral Director	10a. State 10b. County Md Prince Geo  10e. Street and Number 2000 Harewood Rd.  11. Marital Status 1 Never Married XXMarried 3 Widowed 489 worked  (Specify only highest grade Elementary/Secondary (0-12) 6th  17. Father's Name (First, Middle, Last) Walter Pridge	District  Distri	Heights  10f. Zip Code 20747  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pure 1 Yes 2 No Specify:	10g. ( Un:	Citizen of What Cou ited Stat	10d. Inside City Limit 1 AYes 2 Number
Department of Health and Montal Hydrogonia any injury or other treumetic event. I to Be CC	2000 Harewood Rd.  11. Marital Status  1 Never Married XXMarried  3 Widowed Third Prior Status  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6th  17. Father's Name (First, Middle, Last)  Walter Pridge	Armed Forces?  1   Yes 2   ENO	20747  Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 □ Yes 2 ☑ No Specify:	Un	ited Stat	•
Department of Health and Montal Hydrogonia any injury or other treumetic event. I to Be CC	1 Never Married  3 Widowed *** Married  3 Widowed *** New Proced  (Specify only highest grade  Elementary/Secondary (0-12) 6 th  17. Father's Name (First, Middle, Last)  Walter Pridge	Armed Forces?  1   Yes 2   ENO	1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or No- erto Rican, etc.)		
Department of Health and Montal Hydrogonia any injury or other treumetic event. I to Be CC	(Specify only highest grade Elementary/Secondary (0-12) 6th  17. Father's Name (First, Middle, Last) Walter Pridge	College (1-4or 5+) (Give life.			Black, White Specify: Bla	, etc.
Department of Health and Montal Hydrogonia any injury or other treumetic event. I to Be CC	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Walter Pridge	MOTOR	edent's Usual Occupation  Be kind of work done during most of w  DO NOT use retired)	vorking 16b.	Kind of Business/Ir	ndustry
Minimal Management of Manageme				ame (First, Middle, Maide Pridgen		euticai
Department of Department of Department of Important: If any injury or once.	19a. Informant's Name/Relationship (Type Beverly Miles/Daugh	19b. Mailinter 1916	ing Address (Street and Number or Rd. #102	Forestville		
nysician Medical	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	Mt. Zio	omatory or other place) on Cemetery   1-2		Location - City or T altimore,	
rysician → Medical	21. Signatura of Funeral Servica Licensé  23a. Párt 1. Enter the disease, or complic	1 120 4 1111	425 Maryland Ave	Capitol Mort ., N.E. Wasl ac or respiratory arrest.		
ysician a ne burial- Ical Ex	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ABDOMINAL AORTIC Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Onset and Death UNKNOWN
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>a</u> <u>a</u>	Part II. Other significant conditions conditions COLON CANC	tributing to death but not resulting in the $\mathfrak u$	underlying cause given in Part I.	23e. Did tobacco	use contribute to to	he cause of death? pably 4 \(\frac{1}{2}\)Unkno
2 2		HYDRONEPHROSIS		24a. Was an autopsy performed?	prior to co death?	opsy findings availa impletion of cause 2 No
his cer Il direct To B	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	nt 3□ DOA Other: 4 XNursing	eath (Check only one)  Home 5 Residence  28d. Describe how injugate.		y)
urs after death.  Inal Director: After tilled in by the funers  I Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)		28f. Location (Street a City or Town, Star	te)	
within 24 hours a To tha Funaral I completely filled Medical Ce	29a. Certifier (Check only one)  1 Certifying Physical Caramin	<ul> <li>ician: To the best of my knowledge, deather: On the basis of examination and/or invand manner stated.</li> </ul>	h occurred at the time, date and place vestigation, in my opinion, death occurred.	ce, and due to the cause(sourred at the time, date an	s) and manner as s nd place, and due to	tated. the cause(s)
To the comp	29b. Signature and title of certifier	1/11-	29c. License number		ate signed (Month,	
$\widehat{}$	30. Name and address of person who cor Arastoo Yazdani,	mpleted cause of death (Item 23a) (Type, I	9095-9 Print) O1 Georgia Ave.,		2 chim	

			For State Registrar	T loade	State of Ma		nd / Dep	artme	ent of H	lealth and Death		- ,		e 20	04	04471
	Physic	ian	Decedent's Nam	e (First, Middle, Las	t)						2	. Date of D Month	eath Da	av	Year	3. Time of Death
	/Medi	cal		N. Pittma								EBRUA	RY 1	20	04	9:35 P M
7	Exami	ner		If not institution, give						r Location of Dea	ath			c. County		
	Funeral		5. Social Security	D LUTHERAN Number 6. Se		e (In yrs.	last birthday)		ERSTO fer 1 Year	WN If Under 24 Hi	rs. 8	Date of B		ASHII		
. 2	Director		218-30-96	41	□M 217 F	. ,	86 Yrs.	Month	s Days	Hours Mi	n.	(Month, D	ay, Year		PA	ilace (State or Foreign ntry)
	p ,		Usual Residence of	~		10. 0					11.1	arcn.	10,1	717		
	ahov	5	10a. State	10b. County			ty, Town or Lo	ocation							1	Od. Inside City Limits
	the Marylar 28a-f ahow netified at	ecto	MD 10e. Street and Nu	Washingt	on	наз	ncock	104	Ti- Ondo				10: 0	'a' /15		1 ☐ Yes 2 MNo
	death with the Maryland rms 23a or 28a-f ahow	Funeral Director	2 Blue						Zip Code 1750					itizen of W	nat Coun	itry ?
	death ms 23	era	11. Marital Status	TITT	12. Was Decedent I	Ever in U	.S. 13.			ispanic Origin? ( In, Mexican, Pue	Specif	v Yes or N	USA		- Americ	an Indian,
9	or ite	Ξ	1 Never Man	ried 2 Married	Armed Forces?  1 Yes 2 Y	No					rto Ric	an, etc.)			c, White,	
21215-0036	within 72 hours after ene than "natural", or Ite ne Modical Exemine	d by	3 XWidowed	4 Divorced	Year or Dates:			1 L Yes	2 X No	Specify:				Specify:	Whi	ite
5	natu	Completed	(Spe	15. Decedent's Edi cify only highest grad			16a. Dece (Give	kind of v	vork done (	durina most of w	orking		16b. F	Cind of Bu	siness/Ind	dustry
12	withir Bne. than	dmo	Elementary/Second 1.2	ondary (0-12)	College (1-4or 5	+)	Owne:		use retired	"			Do	± a ≓ 1	C-1-	
	filed Hygi other	Ü		(First, Middle, Last)	<del>_</del>		Owne.	L,		18. Mother's Na	ame (F	irst, Middle		tail		es
	Mental Mental arked o	To Be	Leo Benn	ett Noona	n					Mary (	Cati	herin	e Sa	vlor	,	
Maryland	2 should and Men Is marke	_		ame/Relationship (T			19b. Maili	ng Addre	ss (Street a	and Number or F					State, Zip	Code)
	1 and 2 Health em 27 I		David L.	Pittman/S	on		1380	3 Ma	ple R	idge Har	nco	ck, M	D 21	750		
Baltimore,	e de la composición dela composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición dela composición de la composición de la composición dela composición dela composición de la composición de la composición dela composición dela composición dela composición dela composición		20a. Method of Dis	position ☐Cremation 3 ☐I	Removal from State	20b. F	Place of Dispo cemetery, crei	sition (N	ame of other plac	e)	Date	9	20c. L	ocation - (	City or To	wn, State
Ë	permit. Pages Department of Importent; if it any injury or o		`4 Donation	5 ☐ Other (Specify,	) 0	Ced	dar La	vn		02/0	05/0	74	Hag	erste	wn.	MD
3ai	Departition Depart		21 8 gnature of Fe	uneral Service Licens	TI I					s of Facility			141			n Street
	40244		222 Part Fotors	ha disaasa arama	lications that caused	re_	G	rove	Fune	ral Home	<u>,                                     </u>	P.A.	Han	cock,	MD 2	1750-0368
	100		shock, or hea	intialiure. List only o	ne cause on each lin	10.	n. Do not ent	er the m	ode of dyln	g, such as cardia	ac or n	aspiratory a	arrest,		91	Approximate Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	on	a	ukr		nan	-	Accide	<u></u>	_				3-4250
35	Examiner				Due to (or as	a conseq	derice or);									
10		Jer	Sequentially list co	nditions, nmediate	b. Due to (or as a	a conseq	uence of):					177				
	te be executed ysician and te burial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	injury	c											
,092	ite be exe iysician a ne burial-i	EX	resulting in death)	Last	Due to (or as a	a conseq	uence of):									
6876	# × ø	dicai		•	d			-	-			-	_		-	
9 X	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE:		23c. If yes, outcome	of oregona	incv						-1		* *	
Вох	death atten	ciar	in the past 12	months?	1□Live birth 4□Pregnant at	2 □ Feta	Ideath 3	Ectopic Other	pregnancy specify)					23d. Date Mont		ry Day Year
0	at the de by the a tached	hysi	1 ☐ Yes 2 [ 9 ☐ Unknown		9□ Unknown											
ď.	The law requires that the ate has been signed by the bage 2 should be detache	by P	Part II. Dther signif	ficant conditions co	ntnbuting to death bu					en in Part I.		23e. Did 1	tobacco	use contrib	oute to the	e cause of death?
ord	w require been sig should t	ed	Puin	ones	Turbanis	0	Lapon	~i	<del>-</del>			1 🗆	Yes 2	□No 3	B □ Proba	ably 4 DUfiknown
Records,	law ras be	Completed	Dem	entin								24a. Was		24b. W	efe autop	sy findings available
		S										perfo	ormed?	de	ath? Yes :	
Vital	Physicien: Th this certificate al director, pag	Be	25. Was case refer examiner?	_	lo enitel:					26. Place of De	ath (C	heck only	one)			
of	Phys this al dir	7	1 Yes 2 2	10	lospital: 1 ☐ Inpatier 28a. Date of Injur		ER/Outpatien			4 Lyararsing	_					)
o	ding I h. After funer	tion	1 ANatural	5 Pending investigation	(Month, Day	Year)	28b. Time of Injury	м	28c. Injury Work	at ? ∕es 2∐No	280	. Describe	now inju	y occurre	d	
Division	tel or Attending s after death. el Director: After ed in by the fune	Certification:	2 Accident	6 Could not be	28e. Place of Inju	ry - At ho	ome, farm, str				28f.	Location (	Street an	d Number	or Rural	Route Number,
Ö	el or	erti	4  Homicide	determined	building, etc	. (Specify	()		,,			City or To	wn, State	)	0, 1,0,0,	riodio riambor,
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct. completely filled in by the	Medical (	29a. Certifier (Check only one)	1 <b>②-Certifying Phy</b> 2 <b>☐ Medical Exami</b>	sician: To the best o ner: On the basis of and manner stai	examınai	wledge, death tion and/or inv	occurre estigatio	d at the time	e, date and plac inion, death occ	e, and urred a	due to the	cause(s) date and	and mani place, an	ner as sta	ited. the cause(s)
	To tl withii To th comp	ž	29b. Signature and	title of certifier				25	9c. License	number			29d. Dat	te signed	(Month, D	Pay, Year)
	1		-	tonta m	.0				DIS	०१५			FEA	2,	200	04
	16			-	empleted cause of de	-					-					
	'			T DAT-						HAGE	S 1.	704	~ .	uo	21	746
	Sta Registr		31. Date filed (Mon	th, Day, Year)	32 Registra	rs Signa	ture	well								

PITTMAN, Betty Noonan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23aPtII per ME G832 06/22/04dhb

For Amend Item 25 per ME G832 06/22/04dhb

For Amend Item 25 per ME G832 06/19/04dhb

For Amend #8 per FH, G632, 6/23/04dtificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** JONFL ( TERESA MART FEBRUALY 200 4 Will /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 8. Date of Birth **Funeral** 1 □ M 2 1 F Days 0971071952 424-70-0886 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in then "naturel", or Items 23a or 28a-f ehove the Medical Examinar must be notified at 1 Yes 2 No Belcamp Harford W Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4263 21017 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School student and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Health and Mental Florence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Comp 317 AFRH 3700 Capital St. Dw. Washington Do Date 20c. Location - City or Town, State permit. Pages 1 and 2: Department of Health at Important: If Item 27 le any injury or other tracourse. father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition R.A. Ferris & Co. 2-7-2004 Westchester, PA ° 4 ☐ Donation 21. Signature of Funeral Service Licensee Tarring- Cargo Funeral Home, P.A. Aberdeen, MD 21001-3399 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTEACRAMAC Physician ITEMOLRHAGE 2445 /Medical Due to (or as a consequence of): Examiner THI LEGENSION YAARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical as attending p IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9☐ Unknown signed by detache 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2⊠ No or Attending Physician: 25. Was case referred to medical examiner?
1 XYes -2-3-No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ovensy FABRUARY 4, 2004 RF3 - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OVERD 4 WOLFE ST, BALTIMORY NO ZIZET PHILLE 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Month Yeer \*Physician SAMUEL PRICE PFAFF 322 PM FEBRUARY 5 2004 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner HARFORD 300 STOCKHAMS LANE ABER DEEN If Under 24 Hrs. Hours Min. 6. Sex. 1 M 2 ☐ F If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Days Months Director Pages 1 and 2 should be filed within 72 hours efter death with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e4 shot any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Harford Director Mary Rid 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21001 by Funeral 9NP 12. Was Decedent Ever in U,S.
Armed Forces?
10 Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2□ Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: 3 Widowed 4 □ Divorced Yes, Give Year or Dates: Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physici 2 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) layton HUMBERSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8611 Germantown ma on urmeric 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)\* Ferris WestCharter and Address of Facility 21. Signature of Funeral Service Licensee 1333 S. Parke Md Lman St 21001 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ate hes been signed by the attending physician and page 2 should be deteched for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) Part II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yes 2. 1 No 1 🗆 Yes within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?
176 Yes 2 □ No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 - Homicide To the Hospital 1 Certifying Phyeiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D0014206 MD DME 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) HOLABIRD BERNARD UKN A, MD DWE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 12 200-Registrar

			Please	ype or Print					-	_	
			For State Registrar	State of Mar	yıan		tificate of L			/ ! ! ! ! !	. 04477
			Registrar  1. Decedent's Name (First, Middle, Las	"	-		incate of L	Jean	2. Date of Deal	eg. No. —	3. Time of Death
	Physicia	an		ee Robbin	<b>c</b>				Month	Day Year	6/100 11
	/Medic		4a. Facility Name (If not institution, give		3	•	4b. City, Town, or	Location of Death		4c. County of De	
	Examin	er	1 1	1 1 1	050	ital	Cambr	•	D	Dorche	ster
	Funeral		5. Social Security Number 6. Se	7. Age (	_	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		215–38–2493	⊐м <b>Ж</b> У <sub>F</sub> 62		Yrs.	MONUTS Days	riours wiir.	May 16,	1941 м	aryland
	D >		Usual Residence of Decedent  10a. State 10b. County		Oc. Cit	y, Town or Lo	cation				10d. Inside City Limits
	ehov ehov	5	Maryland Dorches		00. 0		t New Mar	rkat			1 ☐ Yes 🏋 🖫 No
7	the N	ect	10e. Street and Number			LKI	10f. Zip Code	Liket	1	0g. Citizen of What 0	Country?
$\alpha$	with the control	Funeral Director	3609 Green Point	Road			21631	1		US	,
7	Jeath	era	11. Marital Status	12. Was Decedent Ev	er in U.	S. 13.	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - An	
9	or He	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give			iYes, specify Cuba 1 □ Yes 21\overline{\delta} No	in, Mexican, Puero Specify:	o Hican, etc.)	Black, Wh	White
21215-0036 0	72 hours after death with the Maryland natural; or Items 23s or 28s-1 ehow Jical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			10 165 221140	Specify.		Зреспу.	WIIICE
5	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired	ation during most of world	king	16b. Kind of Busines	s/Industry
7	within ene. than "	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)		100	Service W			School C	afeteria
D D	Hygie ther ther		17. Father's Name (First, Middle, Last)						e (First, Middle, I		areceria
an	ld be ental ked o	To Be	Paul D. Lee					Marie	Stoker		
Maryland	shoul nd Mi mari	1	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number	, City or Town, State	, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heatht and Mental Hygiene. item 27 is marked other than "naturat", or items 23a or 28a-1 show item 27 is marked other than "naturat", or items 23a or 28a-1 show other traumatic event, the Modical Examiliar mant be notified at		Hollie R. Robbin	s Husband	l	3609	Green Po	oint Road	East Ne	w Market,	MD 21631
ē,	m O	1 8	20a. Method of Disposition	Domousi from State	20b. P	lace of Dispo	sition (Name of natory or other place	e)		20c. Location - City of	or Town, State
altimore,	Pages nent of ant: If it ury or o		'4 □ Donation 5 □ Other (Specify		Ea	st New	Market C	Cem   1/29	/04 E	ast New M	arket, MD
alt	permit. Page Department Important: If any injury or once.		21. Signatur of Funeral Service Licen	see		22 T	Name and Addres	ss of Facility	e P 1		
8	20229		phile I len	er/			00 Locust	Street	Čámbridg	e, Maryla	nd 21613
Е			23a. Pant. Enter the disease, or comp shock, or heart failure. List only	olications that caused the cause on each line.	e death	n. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician	7	Immediate Cause (Final disease or condition resulting in death)	a CARCA	CO	FC	Arry1	13m1	in		30 min
	/Medical Examiner		1	Due to (or as a	conseq	1	. 1 2 1 2	-1 -0-			20 MH
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseq	uence of):	O POTO	ywaciz	oruse		30 1100
(3)	uted 1 ansit	C	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				28				
Ć,	sician and burial-transit	Exami	resulting in death) Last	Due to (or as a	conseq	uence of):					
760	te be ex ysician ne burial	cal	· ·	d							
99	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Medi	IF FEMALE:								
Вох	eath ce attendi for use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	□ Feta	Ideath 3□	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
O.	the at	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of d	eath 5	Other (specify)				
P.O.	that the de led by the a detached t		Part II. Other significant conditions or	ontributing to death but	not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
ds,	uires tha signed I d be det	d by					, , ,		1 □ Ye	es 2. 2. 2. 3 □ 1	Probably 4 Unknown
Ö	w requir been si should I	ete							24a. Wasa	n 24b. Were	autopsy findings available
of Vital Records,	The lavate has	ompieted						<del></del>	autops	ngd? prior to	completion of cause of
a		ပို	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes : th (Check only on	<u> </u>	es 285 No
>	Physician: this certificant all director, is	0 8	examiner? 1 <del>Z Yes</del> 2 ☐ No	Hospital: 1 ☐ Inpatient	2/2	ER/Outpatier	it 3□ DOA Othe	00		ence 6 □Other (Sp	ecify)
		n: T	27. Manner of Death	28a. Date of Injury (Month, Day )	(ear)	28b. Time of Injury	28c. Injun Work	y at k?	28d. Describe ho	w injury occurred	
jo	Attending or death. ector: After by the fune	atic	1 Natural 5 Pending investigation					Yes 2 □ No			
Division	after death after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.			eet, factory, office		28f. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,
۵	oital o urs af raf D										
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical		ysician: To the best of niner: On the basis of e and manner state	xamina	tion and/or in	vestigation, in my or	pinion, death occu	rred at the time, d	ate and place, and d	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7 2			29c. License	e number	2	9d. Date signed (Mo	nth, Day, Year)
	- S - 0		1 Milled	Elead	5	and the same of th	Da	1638	8 3	TAN 26	2004
			30. Name and appress of person who	completed cause of dea	th (Iten	23a) (Type,	Print)	- 1	, / /	11 1	
			Michael to	ddew	Mi	) 30	3 (8111V	45 /1	wilock	mal ?	nth, Day, Year) 2004 9-1643
	Sta		31. Date filed (Month, Day, Year)	2 8 32 (104	s Signa	ture	A Rose	.5			
	Regist	rar	<b>9</b> , 11	1	اناسم		SENT.				

				partment of Health and M ertificate of Death		ene 2004 04478
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
-	Physici /Medio		Isabel Angelina Robertson			22, 2004 11:58 A. M
7.	Examir	er	4a. Fecility Name (If not institution, give street and number) Millennium Health and Rehabilitation	4b. City, Town, or Location of Death Fort Washington		4c. County of Deeth Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
	Director		Usuel Residence of Decedent		May 19,	1903 New York
	yland		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Ba-fel	ctor	Maryland Prince Georges Clinton			1 XYes 2 □ No
	h with th	ai Dire	9106 Pineview Lane	10f. Zip Code 20735	1	Citizen of What Country? Inited States
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 te marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Miccleal Examiner mistal be notified at once.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. 1: Armed Forces?  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. 1: Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto F  1   1   Yes 2 □ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. SpecifySpanish
Maryland 21215-0036	72 hou natura	ted	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16	b. Kind of Business/Industry
21	rithin 7	Completed	Elementary/Secondary (0·12) College (1·4or 5+)	ve kind of work done during most of working DO NOT use retired)		
2	iled w Hygier ther th	Co	8 Ma	anager 18. Mother's Name		Hair Salon
land	id be f ental h ked of ic eve	To Be	Vicente Linares	Carolina		•
ary	and M mar		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural	i Route Number, C	ity or Town, State, Zip Code)
	and 2	ı	Alys Lorraine Bauer/ Grandaughter 3004		ve, Wald	orf, MD 20601
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State CO Was	position (Name of Defendance) Sh. UniversityJanual	ry 22	c. Location - City or Town, State
altimore,	it. Pa intmen intant: njury		Medical	Center 2004	4 V	Mashington, D.C.
Ba	Dermi Depa Impo eny ir		Ma Condo	Columbia Mortuary S P.O. Box 58007 Wash	Services, hington,	Inc. D.C. 20037
8760,	Physician /Medical Examiner buvisicien and properties and the prical-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	OFIC CARD OVAL		Interval Between
.O. Box 6	death certifi e attending od for use as	Physician/Med		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P	s tha	by	Part II. Other significant conditions contributing to death but not resulting in the METASTATIC SQUALLOUS CE		23e. Did tobac	co use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown
000	law require as been sig 2 should b	Completed	/		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Ĭ	The ate h	Com			autopsy performed	f?   death?
Vital	lcian: Th	Be	25. Was case referred to medical examiner?	26. Place of Death		
<u></u>	ding Physia h. After this of funeral dir	tlon: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Inpatient 2 ER/Outpati 28b. Time (Month, Day Year)	of 28c. Injury at 28	e 5 🗔 Residence 8d. Describe how i	e 6 Dother (Specify) njury occurred
Division	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		8f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital within 24 hours. To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1	ith occurred at the time, date and place, ar nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
•	To the within 2 To the complet	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
1	,		100 m	1 1 10575	JA	WAKY 23, 2004
C	_		30 N le and address of person who completed cause of death (Item 23a) (Type P. UNI SOTTING MAIN 12070 BC)	DI-MIS CSATIFE	11 A DRA	E AND 70602
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	p was well a	O (Cont	1 100 1 000
	Registra	ar	JAN 2 8 2004 Bloke & Com	0,0		

			1- For State of Mary Registrar	and / Department of Certificate		ental Hygier	the W W M	04479
	Physic	ian	1. Decedent's Name (First, Middle, Last)  BRIANNA MONIQUE	2		2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  PLINCE GEOLOES IFOS	4b. City, Tov	vn, or Location of Death	FEB.	4c. County of Death	GEORGES
	Funeral Director			vrs. last birthday) If Under 1 Y	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthol	lace (State or Foreign try)
	ith the Maryland or 28a-f show	Director	MARKAND PRINCE GEORGES 3.	309 0006E PH	de	10g.	Citizen of What Count	Od. Inside City Limits 1 ☐ Yes 2 ☐ No try?
36	hours after death with the Maryland turel, or Items 23a or 28a-f show at Examiner must be notified at	by Funeral	11. Marital Status  1. Maver Married 2 Married 3 Widowed 4 Divorced  1. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		of Hispanic Origin? (Spe Cuban, Mexican, Puerto I No Specify:		14. Race - America Black, White, & Specify: BL	etc.
21215-0036	l within 72 liene. r then "nai	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual On (Give kind of work de life. DO NOT use re	one during most of working stired)	ng	Kind of Business/Ind	ustry
Maryland ?	nould be filed a Mental Hygist narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last) BRIAN STEPHEN RUSSE		KATESH	(First, Middle, Maid	ien Sumame) IQUE RU	WELL
	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg mportent: If item 27 is marked other myortent: If item 27 is marked other any injury or other treumatic event, 2008.			19b. Mailing Address (St. 3309 0000)  b. Place of Disposition (Name of complete, grematory of other	E PARK R	D APT. 420	y or Town, State, Zip of Y ANDOUC Location - City or Tov	R, MD 2015
Baltimore	permit. Pages Department of a Importent: If it any injury or o ance.		1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Fulleral Service Censes	MBDBX	Hiross of Facility	04 41 014 /4	41110V	he
1	Priysician		23a. Part1. Enter the disease, or complications that caused the caused the cause (repair tailure. List only one cause on each line.)  Immediate Cause (Final iseas or condition a.	eath. Do not enter the mode of	dying, such as cardiac or	respiratory arrest,		Approxi ate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1			
,8760,	ficate be executed physician and s the burial-transit	dical Examiner	Cause (Usease or injury that initiated events c	equence of):				
P.O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ HO 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ Femant at time 1 ☐ Unknown	etal death 3 Ectopic pregna			23d. Date of delivery	y Day Year
	w requires that been signed b should be deta		Part II. Other significent conditions contributing to death but not	esulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
al Reco	The ate h	Completed				24a. Was an autopsy performed?	death?	sy findings available pletion of cause of
Division of Vital Records,	Attending Physician: It death. ector: After this certifice by the funeral director, p	on; To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Hospital:  27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year	28b. Time of 28c. Ir			6 □Other (Specify) ury occurred	
Divisio		Certification:	2 Accident investigation	M 1	☐ Yes 2 ☐ No	Bf. Location (Street a City or Town, Sta	and Number or Rural F te)	Route Number,
	To the Hospitel or within 24 hours after to the Funeral Discompletely filled in	Medical C	29a. Certifier (Check only one)  1 Cartifying Physicien: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	nation and/or investigation, in m	y opinion, death occurred	at the time, date ar	nd place, and due to the	he cause(s)
16	5≱5§		29b. Signature and title of certifier  Lunn ouge Abelia  30. Name and address of person who completed cause of death (I  EMMANIEZ ATIETTO, MO-300)  31. Date filed (Month, Day, Year)  FEB 1 2 2004	29c. Lice	22924	29d. D	ate signed (Month, Da	iy, Year)
1/2			30. Name and address of person who completed cause of death (I	am 23a) (Type, Print) HOSPITAL DR	IVE, CHEV	ERLY M	0 2018	15
	Sta Registr	te ar	FEB 1 2 2004	A forth				

			1- State of Maryland / Department of Health and I Certificate of Death		giene 2	104	04480
	Dhysia	ion	Decedent's Name (First, Middle, Last)	2. Date of De	ath	Value	3. Time of Death
	Physic /Medi		Samuel Francis Street, Sr.	Janua	cy 12	2004	5:05a <sup>M</sup>
	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County	of Death	
			Berlin Nursing & Rehabilitation Berlin			cester	c
	Funeral		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  7. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthpla Counti	ace (State or Foreign
	Director		217-16-9370 79 Trs.	01/18/	1924	Mary1	land
	/land		10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	Man First	ţ	MD Worcester Berlin				1 Yes 2 No
	r 28e	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Count	ry?
	h wit		9715 Healthway Drive 21811		USA	۸	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28e-f show event, the Marileal Examiner must be multiped at	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton)	ecity Yes or No	- 14. Rac	e - America	
9	or its	臣	1 Never Married 2 Married 1 Types 2 No	Hican, etc.)		ck, White, e	tc.
SAMUEL d 21215-0036	ural',	d by	WWII		Specif		nite
<u>17</u> C	natu	Completed	15. Decedent's Education (Specify only highest grade completed)  [Secondary (Specify only highest grade completed)  [Ife. DO NOT use retired]	king	16b. Kind of B	usiness/Indu	ıstry
2€	withir ane. than	E G	College (1-40r5+)	-			
SP 23	be filed tal Hygie d other	ပိ	12 none Salesman  17. Father's Name (First, Middle, Last) 18. Mother's Name	o (First Middle	Buildin	ng Mat	erials
a,	d be sed o	To Be	01		waiden suman	10)	
E Z	2 should be filed wing and Mental Hygien I is marked other the raumatic event, the	-	Clarence Berry Street Mary Bri  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		r City or Town	State Zin (	Codel
E S	D =		Samuel Street, Jr./Son 32706 West Post Offic	e Road.	Princes	se Ann	21853
STREET, Baltimore, Marylan	permit. Pages 1 and 2 Department of Health important: If item 27 I any injury or other tre		20a. Metriod of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -	City or Tow	m, State
E	Pages nent of I int: If ite		September 2 Electrication of Electrication of Electrication	//2002 T	) m d m n n n =	. A	MD
alti	permit. Pag Department Important: I any injury o	1	21. Signature of Funeral Service Licensee. 22. Name and Address of Facility	4/2003 I	rincess	Anne	• MD
m	80 5 6	0	Hinman Funeral Hom 11673 Somerset Ave		2022 Amm	o MD	21052
			Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	<i>F</i>	Approximate Interval Between
	Physician		Animediate Cause (Final disease or condition a Chronic Obstructive Pulmone	. Di	Curc	ä	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	7			( Lay =
	Examiner		Sequentially list conditions, b.				
_	Sit 9d	ine	il ally, leading to inmediate cause. Enter Underlying Cause, (Disease or injury				
	and and I-tran	Examiner	cause (clisical of injury that initiated events resulting in death) Last  Due to (or as a consequence of):	·			
.09	icate be executed physician and s the burial-transit		Due to (or as a consequence or).				
68760,		edical	d				
Вох	eath certif attending for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		22d Day	o of delices	
ă	death cer attendir d for use	cial	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Vos 3 Ne Pregnant at time of death 5 Other (specify)		Mor	e of delivery oth Da	ay Year
O. 9	that the de ed by the detached	by Physician/M	9 □ Unknown				
Ψ.	s tha	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
ğ	aquire en siç ould b			1 🗆 Y	es 2□No	3 🔲 Probab	oly 4 🗷 Unknown
ည္မ	The law requires tha ate has been signed page 2 should be de	Completed		24a. Was a	ın 24b. V	Vere autops	y findings available
~	The ate his page	É		autops perfor	med? d	rior to comp leath? Yes 2[	y findings available bletion of cause of
ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner? 26. Place of Death			195 21	
Š	hysic his ce I dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho	me 5 Reside	ence 6 Othe	or (Specify)	
٦	ing P	ü.		28d. Describe h			
Sio	tend leath. lor: A the fu	cati	2 Accident investigation M 1 Yes 2 No				
Division of Vital Records,	or At after c Direct in by	Certification:	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Numbe n, State)	or Rural R	loute Number,
_	Hospital 24 hours a Funeral I tely filled		29a. Certifier to Certifying Physicien: To the best of my knowledge death occurred at the time date and place.				
	To the Hospital or Attending Physician: within 24 hours alter death To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier  (Check only one)  (Check one)	and due to the ca ed at the time, d	ause(s) and mar ate and place, <i>a</i>	iner as state nd due to th	ad. ie cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Da	y, Year)
			11/X0711del D28769		1/12	104	
_		+	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 30	tel 1	trakwa		
			Vicholas N. Borochilia, ND Farmick F.	sland.	100 1	199	14
	Sta		31. Date filed (Month, Day, Year) 32. Registrer's Signature				
	Registr	ar	JAN 13 2004 Blown & Soule				

			1 - For State Registrer	State of Maryland /		rtment o				ene	004	04481
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last)     DONNA MARIE SC      4a. Fecility Name (If not institution, give seconds)	HOEN		4b. City, Tow	n, or Locatio		2. Date of Death Month January		Year 004 Ity of Death	3:25 A M
	Funeral Director		214-00-2/50	7. Age (In yrs. last b.		Wald If Under 1 You Months Da			8. Date of Birth (Month, Day, 1)		9. Birthpl Coun	
	the Maryland 28a-f show	rector	Usual Residence of Decedent  10a. State  10b. County  Maryland Charles  10e. Street and Number	10c. City, Tov	wn or Loca dorf	ation	le .		100	. Citizen d		Od. Inside City Limits 1 ☐ Yes 2 ☐ No
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or othar traumatic evant, It a Medical Examinational be mailised at once.	d by Funeral Directo	6233 Seal Place	12. Was Decedent Ever in U.S. Armed Forceş? 1			2060 of Hispanic C Cuban, Mexic	Origin? (Specan, Puerto F	city Yes or No- lican, etc.)	14. Ra	JSA ace - America ack, White, e	an Indian,
Maryland 21215-0036	filed within 72 he Hygiene. ther than "natu int, it e Medical	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, Last)		(Give kii life. DC	nt's Usual Oc nd of work do NOT use re	ne during m tired)		g 16	El	Business/Ind	ustry
Marylan	d 2 should be th and Mental 7 is marked o traumatic eve	To Be	Jack W. Schoen  19a. Informant's Name/Relationship (Type				Co	atheri ober or Rural	ne Virgi	nia R City or Towr	Rosetta n, State, Zip	Code)
Baltimore, I	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or othar once.		Sharon Macuci - Si  20a. Method of Disposition  1	emoval from State Cedar	or Hil	ltory or other Ceme Name and Ad ntt Fu	tery dress of Fac neral	2-5-0	4 Su	itlan	id Mai	vn, State
	Pnysician /Medical Examiner	95	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as Joonsequence	not enter	U. Bo	X 156	. Wald	orf, MD respiratory arres	20604		Approximate Interval Between Onset and Death
8760,	ificate be executed physician and is the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence								
.O. Box 6	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		ctopic pregna Other (specify,					ate of deliver onth [	y Day Year
ords, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions conf	tributing to death but not resulting i	in the unde	erlying cause	given in Pan	t I.		2 No		cause of death?
ital Rec		Se Completed	25. Was case referred to medical				26. Pla	ce of Death	24a. Was an autopsy performe 1 Yes 2 (Check only one)	d?	prior to com death?	sy findings available pletion of cause of
Division of Vital Records,	ding Pl h. After tl funera	ation: To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		utpatient Time of Injury	28c. lr	0.11	Nursing Hom 28	e 5. Residence			
DIVIE	- 9.5	cai Certification;	3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only 2 Medicel Exemin	28e. Place of Injury - At home, fa building, etc. (Specify)	e. death o	courred at the	time date a	and place, ar	Bf. Location (Stree City or Town, S	State)	annar as eta	tod
<b>)</b>	To the Hospital or within 24 hours aft To the Funerel Di completely filled in	Medical	29b. Signature and title of certifier	er: On the basis of examination an and manner stated.	iwor inves		y opinion, deense number $2257$				and due to t	
D	Sta Registr		30. Name and address of person who cor Dr. R. Timothy F 31. Date filed (Month, Day, Year) FFR 0 3 20	Pace, 12070 01d 32. Registrar's Signature	Line		#202,	Wald	orf, MD	20602		

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 Decident Name (First Middle)	State of ivialying		Certificat			R	eg. No.	004	04482
	Physic	ian	1. Decedent's Name (First, Middle, Las	•					2. Date of Deat Month	Day	Year	3. Time of Death
1	/Med		DOROTHY M. SA  4a. Facility Name (If not institution, give	BIN street and number)				4b. City, Town, or L	January		004	5:00 PM
	Exami	ner	Waldorf Health	,				Waldo			Chanal	
	Funeral		5. Social Security Number 6. Se		rs. last birth	day) If Under		If Under 24 Hrs.	· · · · · · · · · · · · · · · · · · ·		Charle 9 Birthol	
	Director		212-14-5972 1D Usual Residence of Decedent	□м 2ХО F 84		rs. Months	Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 10	, 1919	Mary	lace (State or Foreign try) and
	how		10a. State 10b. County	10c.	City, Town	or Location					10	Od. Inside City Limits
	e Ma Sa-f s	cto	Maryland Charles		We	lcome						1 ☐ Yes X ☐ No
	if	Directo	10e. Street and Number			10f. Zip	Code		10	Og. Citizen of	What Count	try?
	ath w		7509 Brentland Roa	d			2	20693		U	SA	
Baltimore, Maryland 21215-0020	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show calcal Examinet must be notified ut	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U,S.	13. Was Deced If Yes, spec 1 ☐ Yes 2		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce · America ack, White, e	etc.
2-0	72 hc	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. [	Decedent's Usua	Occup	ation	, 1	6b. Kind of E		
21	swithin giene. r than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- '	life. DO NOT us	e retirec	during most of work	ing			
7	led w lygier ner th	ខ្ល	12		0ff	ice Adm	inis	trator		In	surand	ce
and	be fill d off	a	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle, M	laiden Surnai	me)	
ž	J Mer J Mer Jarke Jarke	٩	Ward Caddington					Mabel L	ouise Ga	rrison		
Ma	d2st than 7 is n traun	10	19a. Informant's Name/Relationship (Ty					and Number or Rura				Code)
é,	Heall Heall em 2		Judy Conley - Daugl		/ 5U Place of D	9 Brent Disposition (Nam	lano	l Road, We				State State
ō	ages int of t: if it		1 X Burial 2 Cremation 3 □R			Disposition (Nam crematory or oth ection (			11	Oc. Location		m, State
₽	artme ortan injur	1	4 ☐ Donation ☐ ☐ Other (Specify)  21. Sign tup of Funeral Service License						-4-04 6	linton	• MID	
ä	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other tt any injury or other traumatic event, fin once.		Val H John	™ M000	53			eral Home 156, Wald	dorf, MD	20604		
<i>!</i>	Physician Medical physician and Medical physician and mudal-transit as the prival-transi	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	), —		nsequence of):	rd	lo vash	s de	RI-C		Onset and Death
68760,	e be ex sician e burial	edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	, Due to								J
89 xo	eath certificate be executed attending physician and for use as the burial-transit	Σ	resulting in death) Last	Due to	or as a cor	sequence of):						
m į	atter d for u	icia	Part II Other significant conditions	Acile air a de al le constituir de	. 101 1 11						!	
, P.O.	requires that the death cer seen signed by the attendin hould be detached for use	by Physician/	Part II. Other aignificant conditions con	tributing to death but not re	suiting in tr	ne underlying cal	ıse give	en in Part I,	23b. Did tob			he cause of death? bly 4 ⊠Ünknown
Records,	aw requir as been s 2 should	Completed b							24a. Was an performe	autopsy ed?	avail	e autopsy findings able prior to oletion of cause ath?
<b>=</b> F									1 ☐ Yes	2 No	101	Yes 2□ No
VITAL	certificate	Be	25. Was case referred to medical examiner?	ospital:			Otho	26. Place of Death				
5	ran di	<u>د</u>	1 Yes 2 No '" 27. Manner of Teath	1 linpatient 2	ER/Outpa 28b. Tim		Othe c. Injury	4 Mursing Hon	ne 5 🗆 Residend 8d. Describe how			
DIVISION OF	Attending Proysician: It death. Sector: After this certific by the funeral director.	catior	1 ☐ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Inju		Work	? ′es 2⊡No	od. Describe now	injury occurr	ea	
- ;		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm ify)	, street, factory,	office	2	8f. Location (Stre City or Town, .		er or Rural F	Route Number,
1000	in 24 hours after the Funeral Direction of the	edical	29a. Certifier (Check only one) Certifying Physical Examination	cian: To the best of my known: er: On the basis of examinand manner stated.	owledge, de ation and/o	eath occurred et r investigation, ir	the time	e, date and place, a inion, death occurre	nd due to the cau d at the time, date	se(s) and ma and place, a	nner as state and due to th	ed. ne cause(s)
F	within 2 To the comple	Σ	29b. Signature and tille of certifier			29c. l	icense	number	29d	. Date signed	(Month, Da	y, Year)
			P 77/1/4			d	ノ人	1340		3 toba	nent 20	04
Ç.	, ,		30. Name and address of person, who con	npleted cause of death (Ite	m 23a) (Ty	pe, Print)	\	1 100				
D	54	-4	31 Date filed (Month Day Year)	Cert No	110 J	MW	1/2	4 5040	_			
	Stat	е	31. Date filed (Month, Day, Year)	32. Refistrar's Sign	ature	Boarde						

Amended Items 24a & 24b per Physician 01/23/2004 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jan. 2004 Robert Hadley Sanders 7:174PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 17, 1926 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 453-58-5137 77 Yrs. Indiana Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Frederick Emmitsburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7271 Friends Creek Road 21727 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Ves 2 No WWII/
If Yes, Give Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2) No Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: if item 27 is marked other than 'injury or other traumatic event, it a Mainjury or other traumatic event, it a Main injury or other traumatic event, it is Main injury or other traumatic event, it is Main injury or other traumatic event, it is Main injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Military Career 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mervin Hadley Sanders Martha Virginia McMahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mac I. Sanders/son 14311 C Pearre Road Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2004 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation 20 Jan. \* 4 ☐ Donation \_ 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien hed for use as the buria Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼ No 1 Yes 2 💢 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) SpiceHouse 1 ☐ Yes 2 ☐ Mo To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 S. Center St. Thurmont MD 21788 William Harper

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 3 2004

Eleve & Specter

32. Registrar's Signature

			For State	State of Maryla	•	artment of H			/1111	L ALLAI
	-		Registrar  1. Decedent's Name (First, Middle, Last)			incare or i	Jean	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	VII A +	Con	LERI	1		Month	Day Yee	er 1 220
>	/Medic Examin		4a. Fecility Name (If not institution, give s		ا کا کے سا	4b. City, Town, or	Location of De	eeth Ci	4c. County of D	31
	Examin	CI.	5608 Honeysuck	clo Ct.		Frede			Fred	erick
	Funeral		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Birth		Birthplace (State or Foreign Country)
	Director		578-42-6961 <sup>1</sup> X	X 2□F 8	6 Yrs.	Months Days	Hours M	in. 8. Date of Birtl (Month, Day October 3	0,1917 I	taly
	p ,		Usuel Residence of Decedent  10a. State 10b. County	100 C	ity. Town or Lo	antion				10d. Inside City Limits
	aryia •hov	٦			,					1 Yes 257No
	28s-1	ect	Maryland Frederic  10e. Street and Number	K F	rederic	10f. Zip Code			10g. Citizen of What	
	a or 2	ក		Courant		,			•	•
	eath	eral	5608 Honey Suckle	Court 12. Was Decedent Ever in t	US 13 V	21703	ispanic Origin?	(Specify Yes or No-	United St	tates merican Indian.
10	fter d	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes A No	1			(Specify Yes or No- erto Rican, etc.)	Black, W	hite, etc.
8	urs a	ě	₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 🛣 No	Specify:		Specify:	White
9	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28s-f ehow he Madical Examiner must be notillied at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occupa	ation	working	16b. Kind of Busine	ss/Industry
7	ithin Jan	ld <sub>n</sub>	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired,	)			
2	filed w Hygier Sther th		17. Father's Name (First, Middle, Last)		Furni	ture Refi		lame (First, Middle,	<del></del>	e Industry
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the M	Be								
Z	should be and Mental marked o	2	Francesco Scalera  19a. Informant's Name/Relationship (Ty)	oe. Print)	19b Mailin	o Address (Street a			a D'Ambros r, City or Town, State	
<b>≥</b>	od 2 s lith ar 27 io 1 trau		Lisa Wardrop/ Daug	•					Marvland 2	
ē,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City	
Ë	Pages nent of I ant: if its ary or o		12 Burial 2 □ Cremation 3 □ R  14 □ Donation 5 □ Other (Specify)	emoval from State Mt.	•	Cemetery		ery 31,2004	Frederick	Mervland
Baltimore,	- +		21. Signatur Funeral Service License						Funeral Ho	
m	Departiment of the particular in the particular		Darran Can	ille Coll	exe 1	621 Oposs	sumtown	Pike/Fred	derick,Man	yland 21702
	. )		3a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea	th. Do not ent	er the mode of dying	g, such as card	iac or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PROSTA	TE	CANEER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						7
F	LAGITITICS	_	Sequentially list conditions,	Due to (or as a conse						
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to tor as a conse	querica oi).					
	al-trai	xar	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):					
8760,	cate be executed physician and the burial-transit	dical		l						
9	tificat ng phy as th	led								
Вох	ndir use	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of o	,
-	the atte	Physician/Me	in the past 12 months?  1  Yes 2 No	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown  Part II. Other significent conditions con	tabuting to death but not re	sulting in the us	dorbing source cure	n in Bod I	230 Did to	ha aga waa agatahuta	to the cause of death?
ds,	S U	l by	Partin. Other significant conditions con	thouling to death but not re	saking in the ar	idenying cause give	miniraiti.	1 🗆 Y	E-10	Probably 4 Unknown
of Vital Record	w require been sig should t	Completed			· · · · · · · · · · · · · · · · · · ·			-		
Rec	e la has	dm						24a. Was a autops perfor	sy prior t	autopsy findings available o completion of cause of ?
ā	ician; Th certificate rector, pag	e Co	25. Was case referred to medical				00 Di		2 <b>X</b> No 1□Y	es 2 No
=	00 1/4 =	To B	avaminar?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	AF"	eath (Check only or	ence 6 □Other (S)	nacifu)
	g Physer this		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	Contract of the Contract of th		ow injury occurred	o <del>o</del> chy)
jo	Attending r death. ector; Afte by the fune	atlo	Natural 5 Pending investigation	(WOND), Day Your)	Injury		res 2 □ No			
Division	afer death. after death. I Director; After this d in by the funeral of	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Ath building, etc. (Spec	nome, farm, stra ify)	eet, factory, office		28f. Location (S. City or Town		Rural Route Number,
	Hospita 4 hours Funeral ely fille	edical C	(Check only 2 Medical Examir	sician: To the best of my kn ner: On the basis of examin	owledge, death	occurred at the tim	e, date and pla	ice, and due to the c curred at the time, d	ause(s) and manner late and place, and d	as stated.
	To the I within 2 To the I complet	Med	bnej	and manner stated.	Hastick	29c License			9d. Date signed (Mo	
•	F 3 F 8		16. 1 P	4 1 -	of FAGO	8.4 0	105	CT 1 1078 17	1/28/	/
	*		30. Name and addr of person who co	mpleted cause of death (Ite		Print) Hostic		FREDERICK	/	
	4		GEOLGE 1. SHITH.	H.D. 51		111	-	DERICH A	10. 21	701
71	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	_	/			
	Registr	ar	10M 3 O	2004	K	South)				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State AMEND ITEM #16		aryland / Dep 829 3/23/@e				iene g. No. 2004	04485
			Decedent's Name (First, Middle, L					2. Date of Death		3. Time of Death
	Physici		Dorothy Scott	t Selw	av			Month January	Day Year 25, 2004	4:10 P M
1	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death		4c. County of Death	
	Examin	٠,	Heartfields Assis	sted Living		Frederic	k		Frederick	
	Funeral		Social Security Number 6.		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthy	plece (State or Foreign ntry)
	Director		218-03-4747	1□M 2ĀF 8	9 Yrs.	Width, Day's			1914 Virg	inia
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	nastina			_ <del>-</del>	10d. Inside City Limits
	aryla shov	2			roc. Oity, rown or E	ocation				1 ☑ Yes 2 ☐ No
	8a-f	Directo	Maryland Frederic	k	Myersvill	e 10f. Zip Code		1/	og. Citizen of What Cou	
	with the		10e. Street and Number							
	s 234	era	78 Ashley Court	12. Was Decedent I	Ever in U.S. 13	Was Decedent of H			Inited State	
	iten d	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)	Black, White,	etc.
36	urs af	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: Whit	te
ĕ	tited within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, I're Medical Examinat must be notified at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	pation	. 1	16b. Kind of Business/In	
215	7 nin 7. In "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	life.	DO NOT use retired	during most of workii d)	ng		
2	d with	E O	12			<del>s Cler</del> k	SECRETARY	D	epartment :	Store
פ	othe vent,	Be	17. Father's Name (First, Middle, Las	it)			18. Mother's Name	(First, Middle, N	faiden Sumame)	
<u> a</u>	uld be Mental irked o	2	Joshua	Wilso:	n .	SCOTT	Edna		McCahan	
Maryland 21215-0036	s 1 and 2 should be lited within 72 hours atter death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	i Route Number,	City or Town, State, Zip	Code)
Ž	5 € 5 ±		Roberta R. Spragu	ıe / niece					and 21773	
Baltimore,	ges 1 ar t of Hea if item or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3	□Removal from State	20b. Place of Dispe	osition (Name of matory or other place		ate 2	20c. Location - City or To	own, State
Ĕ	Pages nent of I ant: If its ary or o		* 4 ☐ Donation 5 ☐ Other (Spec	city)	Woodlawn	Cemetery	1/28/		ltimore. Ma	aryland
a	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Uo	1	2	2. Name and Addre	ss of Facility Sta	uffer Fu	neral Homes	sp.A.
m	80 = 8 9	1	Kenny X.	10-	$\bigcirc$ 1	621 Oposs	umtown Pi	ke Frede	rick, Mary	Land 21702
			23a. Part 1. Enter the disease, or co	molications that caused y one cause on each in	the death. Do not en	ter the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- //	/	sere lev	· GC	ident	- (Stroke	Onset and Death  Neck
	/Medical		resulting in death)	Due to (or as	a consequence of):	304/01	- CAEC	1.01.67	STION	
	Examiner		Sequentially list conditions,	b						
	D ==	Examiner	cause. Enter Underlying	Doe to (or as	а основершеной of):					
	nd	am	Cause (Disease or injury that initiated events	c						
Ö,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
8760	cate b	dicai	•	d						
Ö	leath certific attending pl		IF FEMALE:	00.11						
Вох	ath ce ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	,		23d. Date of delive Month	ery Day Year
o.	e de the a	Sic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				
<u>~</u>	The law requires that the de site has been signed by the a page 2 should be detached f		Part II. Other significant conditions	contributing to death b	ut not reculting in the I	Indertying cause alv	on in Part I	23e Did tob	acco use contribute to ti	he cause of death?
ŝ	res ti signe	þ	La sa sa da	to death be	at not resulting in the t	indenying cause giv	en in raiti.	1 ☐ Ye	57	
oro	w require been si should t	ted	ryper ter	LSI ON				-		
Vital Records,	a law nas b e 2 s	Completed						24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
=		S						perform 1 ☐ Yes 2	No 1 ☐ Yes	2□ No
/ita	cian sertifii sector	Be	25. Was case referred to medical examiner?	Hospital		Oth	26. Place of Death	(Check only one	)	Assisted
) t	Physi this c	은	1 ☐ Yes 2 No	Hospital: 1 Inpatie			4   Mulsing Hor			y)
Division of	tending Ph leath. tor: After th the funeral	o	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Wor		28d. Describe how	w injury occurred	riving tack
Sic	tend leath tor: the f	cat	2 Accident investigate 3 Suicide 6 Could not	ho	ury - At home, farm, st		Yes 2 □No	18f Location /Str	eet and Number or Rura	al Pouto Number
$\leq$	or Attendater deati	Certification:	4  Homicide determine	building, etc	c. (Specify)	reet, factory, office		City or Town,		ir noble Number,
_	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying I	Physician: To the best of	of my knowledge, deal	b accurred at the time	no data and place a	and due to the se	una(a) and manner on a	tatad
	Hos 24 hc Fun stely	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, da	te and place, and due to	the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	2.10411101 312		29c. Licens	e number	29	d. Date signed (Month,	Dey, Year)
	ة ≯ ⊢ %		. \4	hat 113	2 252	D37	643		1/28/11.	
			00 N	hah Hire	noth /ltom 22a\ /Time	Print)	1		1-3/04	
1	0		30. Name and address of person wh	completed cause of de	eam (nem 23a) (Type,	Dr Fr.	Pd = - P	MD	2/200	
04	CA		31. Date filed (Month, Day, Year)	nas 32. Registri	s Signature		CENUR	עייט	702	
	Sta Registr		JAN 2	o completed cause of de 2004	lave &	Societies				
	41		40.1114	-		200				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Floyd Bradley Smith January 26 2004 10:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 529 West "B" Street Brusnwick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Aug 13 **Funeral**  Birthplace (State or Foreign Country) Days Hours 1⊠M 2□F 214-28-2386 72 Yrs. Director 1931 Brunswick, MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 7 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Evandrer must be notified at 10d. Inside City Limits Frederick Brunswick Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 529 West "B" Street 21716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? N∑Yes 2 □ No If Yes, Give Year or Dates: Korean 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other treumatic event, the Medical Exeminations. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White δ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Body Mechanic Jenkins Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Bradley Wmith Freda Naomi Spurrier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 529 West "B" Street, Brunswick, MD 21716 Patricia A. Smith, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) Marvin Chapel Cemetery 1/31/2004 Mt. Airy, MD 21. Signature of Furneral Service Licensee 22. Name and Address of Facility
John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) **Physician** enkemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause (Liesace or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exam attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the aid be detached f 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Zunknown 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: nerel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending r death. М investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) -ZHEGHZIMD 04 44104 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 48 Kohnson Dr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2004 > Registrar Markey

State of Maryland / Department of Health and Mental Hygiene State Registrar Amended #5perFH FCHD, KS Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:15 PM 23 2004 January David E. Stone, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Beverly Healthcare Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 225-44-1197 6 Sex **Funeral** Months 1⊠M 2□F 1933 4, Virginia 70 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County items 23a or 28a-f ehow ner rout be notified at 1 1 Yes 2 □ No Maryland Frederick Frederick Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 Carroll Creek View Court 21702 United STates deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status the Medical Examiner: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Depertment of Health and Mental Hygient Important: If item 27 is marked other that eny injury or other traumatic event, that once. Claims Representive Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maude Harris David E. Stone, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, MD 21702 Linda S. Stone / Wife 2121 Carroll Creek View Court 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 28, 2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crozet, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Rockgate Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): reck **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ lise ase with dementio 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D46075 to trull mit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary P. 65 Thomas Johnson Drive Frederick, MD 21702 Howell, M.D. 32. Registrar Signature 31. Date filed (Month, Day, Year) State 2004 28 Registrar JAN

State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

Reg. No. 2004 0488

	Physicia /Medic		WILBUR LERO		GER						Day 20	Year	:00 AM
	Examin	_	4e Fecility Name (If not institution, give : 30287 HARRIS RANG				41	•	wn, or Location	of Death	4c. County		
Ī	Funeral Director		5. Social Security Number 6. Sep. 1216-42-8835		. <i>last birthdey)</i> Yrs.	If Under 1 Months [	Year Days	If Under 2 Hours	Min. 8. Da	te of Birth onth, Dey, Ye.	ar) 2	9. Birthplace Country) MARYLAN	(State or Foreign
	Merylend f show	JO.	Usuel Residence of Decedent           10a. State         10b. County           MD         TALBOT	10c. Ci	ity, Town or Lo								nside City Limits ☐ Yes 2 🛣 No
	ith with the Meryle 23a or 28a-f shou ust be notified at	Direct	10e. Street end Number 30287 HARRIS RAN	CE DOAD		10f. Zip Co	ode 216	25		10g.	Citizen of V	What Country?	
מאַ	after des or items miner m	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Date 1.962—			t of His	spanic Orig n, Mexican,	gin? (Specify Y , Puerto Rican,	es or No- etc.)	14. Rac	ce - American Inck, White, etc.	
00-61717	within 72 hours iene. than "naturel", the Medical Exe	Completed	15. Decedent's Edu (Specify only highest grede Elementary/Secondary (0-12)	cetion e completed) College (1-4or 5+)	(Give	dent's Usuel C kind of work of DO NOT use	doné d retired)	u <i>ring most</i>	of working	16b		usiness/Industr	у
lana	uld be filad Aental Hygi rked other tic event,	o Be C	17. Father's Neme (First, Middle, Last)  JOHN ANDREW SCHIL	LINGER					r's Name <i>(First</i> 'H <b>WADE</b>	, Middle, Maid	den Surnan	ne)	
Mary	nd 2 shou alth and M 27 is mari r treumat		19a. Informant's Name/Relationship (Ty CHARLOTTE ANNE SCH									State, Zip Cod D 21625	(e)
more,	Pages 1 a nent of Hea nut: If item iry or othe		20a. Method of Disposition 1	tomoval from State	Place of Dispo cemetery, crei ESTERFI	matory or othe	er place		1-29	9-2004		City or Town, S	
Dall	Departm Departm Importa eny inju		21. Signature of Funeral Service License	Hellenter								AL HOME MD 2161	
Sec.	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or		th. Do not ent	ter the mode of	of dying	, such as o	cardiac or resp	iratory arrest,		App	roximate rval Between set and Death
agai <sup>t</sup> .	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	metastat  Due to (	or as a consec	JIN 9	C	an co	ev_			mo	withs
	cuted nd ransit	Examiner	Sequentially list conditions,	Due to (	Cance or as e consec	quence ol):				-		ile	ars
,09/90,	daath certificate be executed e attending physician and of for usa as the bunal-fransit	ician/Medical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	Due to (	or as e conseq	juence of):							
7. DOX	daath ce he attendii led for usa	CO	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cau	se give	n in Part I.	2	3b. Did tobac	co use co	ntribute to the	cause of death?
ر. ۲.	w requiras that the da been signed by the a should be datached	by Phy								1 🗆 Yes	2□ No	3 ☐ Probably	
	law requiras that as been signed b a 2 should be date	Completed							24	ta. Was an au performed	itopsy ?	availabl	utopsy findings le prior to tion of cause n?
	an: The la tificata ha tor, paga	Be Com	25. Was case referred to medical					26. Place	of Death (Che	1 Yes	22/10	1 □ Yes	s 2 No
5	Physician this central direction	유	examiner? 1 Yes 2 No  27. Manner of Death	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Dey Year)	ER/Outpetier		Othe Injury Work	401401	rsing Home 5	X Residence			
IVISION	To the Hespital or Attending Physician: The law within 24 burus aftar death.  To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2:	Certification:	1 Statural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h	Injury nome, farm, str	М	1 🗆 ነ	r ∕es 2□N	28f. Lo	cation (Street ty or Town, St	and Numb	ber or Rural Ros	ute Number,
_	• Hospitai 124 hours a • Funeral I letaly filled	edicai Ce	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knother: On the basis of examination and manner steted.	owledge, deatl ation and/or in	h occurred et i vestigation, in	the time	e, date end inion, deatl	d place, and du th occurred et t	e to the cause he time, date a	e(s) and ma and place,	anner as stated end due to the	cause(s)
•	To the complete	Me	29b. Signature end title of certifier	theel		29c. L	icense	number 27		29d.	Date signe	d (Month, Day,	Year)
			30. Neme end address of person who co KATHLEEN HOEY, M	mpleted cause of reath (Item.D., 2540 CEN	m 23e) (Type,	Print) LE ROA	D, (	CENTR	EVILLE,	MD 21	617	,	
· ·	Sta		31. Dete filed (Month, Day, Year)	32 Registrer's Sign									

State

Registrar

JAN 2 7 2004

### Piease Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Jan **Physician** 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner RESTON CAROLIN Jonestown Lane if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 28-6823 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 @ No **Funeral Director** 10f, Zip Code 10g. Citizen of Whet Country? 21655 ONESTOWN LANE Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No UNK If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 INo Specify: δ 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) tarming Unk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DONN Laddie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Prestin, Y MARY land 3/6.55 y 20c. Location - City or Town, State UNK 7 P. O. Box 123. Pr 20b. Place of Disposition (Name of cametery, crametory or other place) WNK Samuel 20e. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 23a. Part | Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. md.21643 Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical INFARCTION, ACUTE Examiner Physician/Medical Examiner use as the bunal-trensit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as e consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 🗆 Yes 260 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 2 No Medical Certification: To 1 Yes 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Physician: The law requires thet the deeth certificate be executed Division of Vital Records, P.O. Box 68760, hes Director: After this certificate I or Attending completely filled in by within 24 hours effer To the Funeral Dire

filed within 72 hours efter death with the Marylend

Peges 1 end 2 should be

ō

Depertment

Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie enseu M completed cause of death (Item 23a) (Type, MD, POB#690) 30. Name end eddress of person who C.E. JENSON MD

State Registrar

31. Dete filed (Month, Day, Year)

32,



**DHMH 16 Rev 6/95** 

		For State Registrar	State of Maryland / D	)epa	rtment		Ith and	Mental Hy		200	0.4	490
	O'	1. Decedent's Name (First, Middle, Last	)					2. Date of De	ath		3. Time of	f Death
Physic /Medi		MATTIE	STELL					Month 1	20	2002	3:3	0 P <sup>M</sup>
Exami		4a. Fecility Name (If not institution, give			4b. City, T	Town, or Loc	ation of Deat	1		. County of De		
		BOWIE HEALTH CL  5. Social Security Number 6. Se.		for after 14	If Under		OWIE Inder 24 Hrs.	la Day at Dia			GEORGE'	
Funeral Director			TM OTTE				ours Min.	8. Date of Bir (Month, Da 2 4	193 193	8 9. 8	irthplace (State of Country) ALABAMA	or Foreign
5-0036 72 hours after death with the Maryland natural', or lems 23a or 28e-f show alea Examiner must be notified at	Director	10a. State 10b. County  MD PRINCE GE	ORGE S BOWIE		ation						10d. Inside Ci 1 X Yes	ity Limits 2 ☐ No
with th	Die	10e. Street and Number	DD TD CE DO AD		10f. Zip (				-	tizen of What C	Country?	
eath 1	era	17006 QUEEN ANNE	12. Was Decedent Ever in U.S.	12 14/	2071		in Origin? (S	nonifu Van as Na		. S . A . 14. Race - Am	adaga ladiga	
15-00:36 72 hours after death with the Marylan '72 hours after death with the Marylan 'antural', or items 23a or 28e-f show oldest Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1  Yes 2  No If Yes, Give Year or Dates:		Yes, speci		ecify:	pecify Yes or No o Rican, etc.)		Black, Wh		
Maryland 21215-0036 nd 2 should be filed within 72 hours aff th and Mental Hygiene. 27 le marked other than "natural", or rtraumatic event, the Medical Exern	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give ki life. D	ent's Usual ind of work O NOT use HIER	Occupation k done during e retired)	most of wor	king		ind of Busines	s/Industry	
e filed wet Hygie other t		12 17. Father's Name (First, Middle, Last)		CASI	TLEK	10	Mathor's No.	ne (First, Middle,		ACK		
and de familiaria la compara la c	Be.	EDDIE BELL						ae Osboi		Surname)		
Tarylan 2 should be and Mental ie marked aumatic ev	2	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b.	Mailing	Address (			ral Route Numbe		or Town, State,	Zip Code)	
		MORRIS STELL/HUS	BAND 17	006	QUEE	N ANN	E BRID	GE RD. E	BOWI	E, MARY	LAND 20	716
		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	tellioval floili State	r, crema	atory or oth	her place)	1-26	Date -2004 E		ocation - City o	r Town, State	
baltimo permit. Pages Department of Important: If I eny injury or o		21. Signature of Funeral Service Licens	a 10					B. JENK D LANDOV				5
Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not be cause on each line.  Due to (or as a consequence of	M			ch as cardiac		rrest,		Approximate Interval Bett Onset and D	ween
6U, be executed ician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of								1	
The Cords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pred Other (spec					23d. Date of de Month	,	/ear
cords, F.C.  **requires that the de been signed by the should be detached.	b	Part II. Dther significent conditions con hypertens		the und	lerlying cau	use given in	Part I.	23e. Did to		_	o the cause of de	
	e Completed	25. Was case referred to medical						1 Yes	rmed?	prior to death?	utopsy findings a completion of ca s 2 No	
OI VITA Physician: rthis certificated in this continuity rall director.	0 3	examiner?	lospital: 1 □Inpatient 2 X ER/Out	nationt	3□ DOA	04		th <i>Chack on o</i> o ome 5 ☐ Resid		2 (10)		
Attending Physic death.  ector: Atter this by the tuneral di	tlon; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti			c. Injury at Work?		28d. Describe h			eciry)	
DIVISION Attents at or Attents a after death In Director: od in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fame building, etc. (Specify)	n, stree	t, factory,	office		28f. Location (S City or Tow			ural Route Numb	ber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely lilled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death o	eccurred at stigation, in	the time, da	te and place, death occur	and due to the cred at the time, c	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
To ti To ti comp	×	29b. Signature and title of certifier	111-		29c.	License num	_		29d. Dat	e signed (Moni	th, Day, Year)	
		1 6 6	me me	)		93	582	2	Ì	1221	04	
(10)		30. Name and address of person who co	0. 14300 balla.	ype, Pri	int)	lane #	-110	BOWLE	_, ~	0 2	0715	
Sta Registi	-	31. Date filed (Month, Day, Year)  JAN 2 8 2004	32. Registrar's Signature	2000	,							

			1 - State Amend Item/20b,		aryland / Depa 82/17/04 <b>D</b> e				ene 1. No. 200	14 04491
F	Physici		1. Decedent's Name (First, Middle, Last) Joyce A Sewa					2. Date of Death Month Jan 2	22° 20°	3. Time of Death 7:26pm
	/Medic Examin		4a. Fecility Name (If not institution, give s Washington Adv		Hospital		r Location of Death		4c. County of I Montg	Death
	Funeral Director		2.00	M 25F	(In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) May 4,	1967	Birthplece (State or Foreign Country) D C Washington
	death with the Maryland ms 23a or 28a-f ehow Fridel be notified at	tor	Usuel Residence of Decedent  10a. State		10c. City, Town or Lo Capital		5			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	al Director	109 Street and Number Daimler D	rive		10f. Zip Code 2074	13	100	J. Citizen of Wha	
21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene. Id other then "natural", or items 23a or 28a-f ehow event, the Medical Exacinat mark be notified at	Completed by Funeral	11. Marital Status  1  Never Married 2 Married 3  Nidowed 4 Divorced  15. Decedent's Educ (Specify only highest grade		16a. Dece	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ▼ No  dent's Usual Occup kind of work done in DO NOT use retire  DOKKEEPE	an, Mexican, Puerto Specify:  ation during most of work	Rican, etc.)	Black, \	,
Maryland 21	2 should be filed wing and Mental Hygien i emarked other thrancatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrumatic event, Instrument, Instr	To Be Con	12 17. Father's Name (First, Middle, Last) William Seward			okkeepe		e (First, Middle, Ma	iden Sumame)	
	D = C =		19a. Informant's Name/Relationship (Type Mark Fletche	•		ng Address <i>(Street</i> 90 Daiml			•	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other ance.		20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License		20b. Place of Dispo cemetery, cre. Mt. Ol: Chesapeake	osition (Name of matory or other place LVEL-COM Crematory	2/19/	Date 20	oc. Location - City seltsville Wash.	y or Town, State . Md . C .
8760,	Physician /Medical Examiner   physician and physician and the phys	dicai Examiner	23a. Parti. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Saturately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to	the death. Do not entered by the death of th	ter the mode of dyin	/	or respiratory arres		Approximate Interval Between Onset and Death
P.O. Box 68	death certifu e attending p id for use as	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		1	23d. Date of Month	f delivery Day Year
Ś	sign d be	by P	Part II. Other significant conditions conditions	tributing to death bu	ut not resulting in the u	inderlying cause giv	en in Part I.		_	te to the cause of death?
I Reco	The law ate has b page 2 sl	Completed	generalize	ol De	elility			24a. Was an autopsy performe	prior deat	e autopsy findings available r to completion of cause of th? Yes 2 \( \sum \) No
Division of Vital Record	Attending Physician: Thir death. ector: Atter this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1  Yes  No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injur Wor	er: 4 🗆 Nursing Ho	h (Check only one) me 5 Resident 28d. Describe how		Specify)
Divisi	at or Attences atter death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	iry - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
)	To the Hospital or Attenwightin 24 hours after death	Medical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin 20h. Signature and title of certifier  30. Name and address of person who core of the filed (Month Day, Year)	er: On the basis of and manner sta		vestigation, in my o	pinion, death occur	red at the time, date	and place, and	due to the cause(s)
(G	Sta Registr		SURESH K: KH 31. Pate filed (Month, Pay Year)	ETAN, N	10 7610	CARROL	LAVETIL			,

			1 For 1-29-04	State of N	/laryland / I			lealth and M	fental Hygi	ene	1 01100
			RegistrarAmend #4.Per	MEO PGC cr		Cei	tificate of	Death		g. No. 🚄 U U	A 114475
	Physici	an	Decedent's Name (First, Middle, La						2. Date of Death Month	Day Vo	3. Time of Death
>	/Medic	al	Michael	Sears			th Chi Taur	al casting of Dooth	January	4c. County of E	
	Examin	er	4a. Fecility Name (If not institution, given 13400 D1116 D11	s Correction	onal Facil	ity		or Location of Death	ro		George's
	Funeral				Age (In yrs. last bi		If Under 1 Year		8. Date of Birth (Month, Day,		Birthplece (State or Foreign Country)
	Director		577-64-3890	1 <b>X</b> M 2□ F	55	Yrs.	Months Days	Hours Min.	Jan. 5,	1949	Wash., DC
	pu ,		Usual Residence of Decedent		10c. City, Tow						
	aryla shov	Ä	10a. State 10b. County	_		m or Lo	cation				10d. Inside City Limits 1 XYes 2 ☐ No
	the M	Director	Maryland Prince	George's			Upper Ma	arlboro	10	g. Citizen of What	
	with a or		13400 Dille	Drino			Tot. Zip Code	20772	10		ed States
	ms 23	Funeral	11. Marital Status	12. Was Deceder		13. \	Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-	14. Race - A	merican Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene od other than "natural", or Items 23e or 28e-f show event, the Madical Existing of an instilled at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	]No	'	fYes, specify Cuba 1 □ Yes 2 □XNo	Specify:	Rican, etc.)		Mriean merican
20	72 ho natur	Completed	15. Decedent's E (Specify only highest gr	ducation	16a	Dece	tent's Usual Occup	pation during most of work	ing 1	6b. Kind of Busine	ess/Industry
2	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	DO NOT use retired	d)	""9		
	led w lygier her th		12th	41			Bank 1		<i>(5)</i>		ernment
and	ntal F ed ot ed ot	Be	17. Father's Name (First, Middle, Last Charles B.					18. Mother's Name	Beatrice	-	-
Maryland	12 should be fited within n and Mental Hygiene. Fis merked other than " reumatic event, the Me.	10	19a. Informant's Name/Relationship		191	. Mailin	n Address (Street	and Number or Rura			
Σ S	nd 2 still ar 27 ls		Michelle R. Sea				-	ed Wood (			
ē,	s 1 and 2 of Health a Item 27 is other tree		20a. Method of Disposition		cometa	f Dispo	sition (Name of natory or other place		Date 2	0c. Location - City	or Town, State
E	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		8			ry 1/29	/2004	Clint	on, MD
Baltimore,	permil. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other treumatic enones.		21. Signature of Funeral Service Lice	Varant	TI	22	Name and Addre	ss of Facility St	ewart Fu		
	4		23a. Part1 Enter the disease, or comshook, or heart failure. List only	nplications that cause	ed the death. Do	not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	hana	1						Onset and Death
	/Medical		resulting in death)		a conservence	of):					
100	Examiner		Sequentially list conditions,	b							
	ed sit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Dispase or injury	Due to (or a	is a consequence	ot):					
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence	of):					
68760,	cate be execut physician and the burial-trar	dicai E		d							
89											
.O. Box	that the death certified by the attending detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2  Fetal death at time of death		Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
<u>α</u>	res that the igned by th be detache	y Ph	Part II. Dther significant conditions	contributing to death	but not resulting i	n the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	e to the cause of death?
ords,	w requires been sign should be								1 ☐ Yes	2 No 3	Probably 4 Unknown
l Record	e law has b	Completed		·					24a. Was an autopsy performe	prior	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Harrier.				26. Place of Death	Check onl one		
of	S S E	L L	1 XYes 2 No	Hospital:	-		3 DOA Oth	4   Nursing Hor			pecify) At scene
uo.	ding h. After fune	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of In (Month, D	ay Yeer)	Time of njury	Wor	yat k? Yes 2 No	28d. Describe how NYCHE W	injury occurred	eltin
Division	l or Attending after death. Director: Afte in by the fune	fica	3₽ Suicide 6 □ Could not b	28e. Place of Ir	- C4 /	rm. stre			28f. Location (Stre	et and Number of	Rural Route Number,
á	el or A s after al Dire	Certification:	4 Homicide	building, e	PCI 500		11.9			Batelle 1	x, gg
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Exer	hysician: To the bes miner: On the basis and manner s	t of my knowledge of examination an	e. death	occurred at the tin	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner e and place, and c	as stated
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	· Po	De	L A .	O.C.M	e number I.E.	290	January	onth, Dey, Year) 11, 2004
_/	3)		By Name and address of person who	completed cause of	death (Item 23a)	(Type, I	Print) 111 Pe	enn Street	t, Baltim	ore, Mar	yland 21201
	Sta	te	31. Date filed (Month, Day, Year)	ON CA -	trar's Signature	in	MY				
4	Registr		JAN 2 9 2004	Blend	trar's Signature	di	,				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 2004 19:02 PM Geraldine C. Saxon January /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cheverly

| If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 1926 Gladys Spellman Nursing Home Prince George's If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Wash., DC **Funeral** Days Months 1□ M 2⋤F Yrs. 578-40-7529 78 Director Usuel Residence of Decedent e filed within 72 hours after death with the Maryland bi Hygiene. other than "natural", or items 23a or 28s.4 show 10b. County 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits 1 Yes 2 □ No Directo Prince George's Maryland Seat Pleasant 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20743 6511 Adak St. United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates: ð Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th College (1-4or 5+) Clerk IRS - Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 and 2 should be fii ment of Health end Mentel H lant: If item 27 is merkad ott Be Joseph Cook Cauline Harvey 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 6511 Adak St., Seat Pleasant, MD <u> Shaaron R. Saxon - Daughter</u> 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If II any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2/7/04 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis Examiner Due to (or as a consequence of): Physiclan/Medical Examiner Congestive Heart Failure or Attanding Physician: The law requires thet the deeth certificete be executed use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of). Division of Vital Records, P.O. Box 68760 Hypertensive Heart Disease Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Coronary Artery Disease þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Aspiration Pneumonia completion of cause of death? 1 ☐ Yes ZX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Netural 2 Accident efter death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide à Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) りてフェフフ υŚ 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Ophnell Cumberbatch, M.D. 8416 Central Ave., Landover, MD 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signeture State JAN 2 9 2004 Registrar

DHMH 16 Rev 6/95

			_			<b>delible ink. Ensur</b> artment of Health ai	•	•	e.
			1 - For State Registrar		-	rtificate of Death	-	Reg. No.	14 04494
	Physici	an	1. Decedent's Name (First, Middle, Las	it)			2. Date of Dea Month		3. Time of Death
a a	/Medi			mith, Jr.			January	23, 200	4 10:45 a <sup>M</sup>
-	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Location of		4c. County of	
			4803 Hollywood R 5. Social Security Number 6. Se		last hirthday)	College Par			George's
	Funeral Director			M 2□F 61	Yrs.		Min. (Month, Pa)	1942 Wa	Birthplace (State or Foreign Country) ashington, DC
	yland how		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation	·		10d. Inside City Limits
	e Mar	cto	Maryland Prince G	George's C	ollege	Park			1 X Yes 2 □ No
	ith the	Dire	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	t Country?
	ath w	ia	4803 Hollywood Ro			20740		U.S.A.	
"	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jigal Exami ner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🎇 No	l	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, V	American Indian, White, etc.
93	ral', o	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I ☐ Yes 2፟፟ No Specify:		Specify:	White
Baltimore, Maryland 21215-0036	y within 72 hours after death with the Marylan jiene. r then "natural", or Itams 23e or 28a-f show the Medical Examirat must be notified at	Completed by	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	16b. Kind of Busin	ess/Industry
7	filed wil Hygien other th	Con	10		Heavy	Duty Mechanic		State of	Maryland
Ind	e d fa	Be	17. Father's Name (First, Middle, Last)	1 0			Name (First, Middle,	•	
уlа	should be ind Mental s marked ( umatic ev	2	Paul Anthony Smit				ret Anne D		
Nar	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1 3	19a. Informant's Name/Relationship (7	** *		g Address (Street and Number			
e, l	1 an Heali em 2		Georgia L. Smith -  20a. Method of Disposition			Hollywood Road	Date Date	Park, Mar 20c. Location - City	
Ö	Pages nent of int: If it iry or o		1 🔀 Burial 2 ☐ Cremation 3 🗆			sition (Name of natory or other place)			
를	그 분 원 구 .		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen:</li></ul>						, Maryland
Ba	Dermi Depa Impo any ir		Clay dato 9	1 4	na 47	Name and Address of Facility (	Gasch's Fun	neral Hom	e, P.A.
			23a. Part1. Enter the disease, or comp	dications that caused the deat	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	J) Dartimole H	venue, nyai	-rsville,	MD 20781 Approximate Interval Between
	Physician		shock, or heart failure. List only of immediate Cause (Final disease or condition		D				Onset and Death
	/Medical		disease or condition resulting in death)	a. Acute Bronch		monia			1 Day
	Examiner		Sequentially list conditions	Cirrhosis of	f Liver				3 1/2 Years
	ed isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t		.1 Di			
•	xecut and al-trar	Examin	that initiated events resulting in death) Last	c. Peripheral A		ıl Disease			9 Years
760,	eath certificate be executed attending physician and for use as the burial-transit	caiE		Diabetic New	,	ıy			15 Years
89	ifficate g phy as the			u		,			
Вох	death certifical e attending phy d for use as th	M/ng	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy		23d. Date of	delivery
	the dea y the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify)		Month	Day Year
P.0	s that the de ned by the s detached	Ph	Part II. Other significant conditions co	untributing to death but not resi	ulting in the un	derlying cause given in Part I.	23e. Did tol	pacco use contribut	e to the cause of death?
Vital Records,	The law requires that ate has been signed b page 2 should be deta	ed by					1 <u>X</u> 1 Y€	es 2□No 3□	Probably 4 🗆 Unknown
ဝ၁	e law re has bee	Completed	-				24a. Was a		autopsy findings available
Ĕ —	The ate has page	Com					— autops perforr 1 ☐ Yes 2	ned? death	
/ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?				Death (Check only on		
	hysi this c al dire	P	I Les ZIXINO	Hospital: 1 Inpatient 2	_		ng Home 5 🕅 Reside		Specify)
Division of	I or Attending Physicien: The later death. Director: After this certificate ha in by the funeral director, page	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
isi	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm stre		28f Location (St	reet and Number o	Rural Route Number,
2	al or A s after il Dire	Certification;	4 Homicide determined	building, etc. (Specify	")	or, radiory, ornor	City or Town	, State)	riulai rioute ivambel,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1⊠ Certifying Phy (Check only one) 2 ☐ Medical Exami	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time, date and pestigation, in my opinion, death of	lace, and due to the ca occurred at the time, da	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
	To the within 2 routhe comple	Σ	29b. Signature and title of certifier			29c. License number		9d. Date signed (Mo	* *
y			> SANA	25		D0013668		January 2	23, 2004
	(20)		30. Name and address of person who co						
			Azher Hussain, MD 31. Date filed (Month, Day, Year)	4917 Edgewood		, College Park	, Maryland	20740-14	39
	Sta Registra		JAN 2 9 2004	Bleen &	Sport				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Emmett Sullivan 26, 2004 1:00 p January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 3404 Duke Street College Park
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. July 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days 1MM 2□ F Hours 83 130-09-8969 New York Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits al Hygiene.
I other then "natural", or Items 23s or commonent, the Medical Exercine must be notified at 1 Yes 2 □ No Maryland Directo College Park Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Duke Street 20740 U.S.A. Completed by Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or item any injury or other traumatic event, the Medical Exerci 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physicist Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Sullivan Florence J. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donal Joseph Sullivan - Son 7635 Tred Avon Circle, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 1/31/2004 Silver Spring, MD 22 Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Serviced icens 004 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Squamous Cell Cancer Nose years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed?

1 Yes 2 ANo Hospital or Attending Physician: Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) DC18561 January 28, 2004 30. Name and address of person who completed caus of eath (Item 23a) (Type, Print) 110/Irving David J. Perry St. NW, Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2004 Registrar

Descention shows from Models Lated    Descention shows from Indiana, page autor and models   20 day			1 - For State Registrer	State of Ma		/ Depa		of H	ealth and	•	ygien	e 2001	+ 0449
Alburn System (Medical Statistics) passed and medical statistics passed and medical Statistics (Medical Statistics) passed and medical Statistics (Medical Statistics) passed and medical Statistics (Medical Statistics) passed and medical Statistics (Medical Statistics) passed and medical Statistics (Medical Statistics) passed and medical Statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics (Medical Statistics) passed and medical statistics) passed and medical statistics (Medical Statistics) p				ast)				- O, L					3. Time of Death
Southern Maryland Hospital  Clinton  P.C.  Soverescon, Warrison  Control Clinton  P.C.  Soverescon, Warrison  Control Clinton  P.C.  Soverescon, Warrison  Control Clinton  P.C.  Age (See No. 1985)  Soverescon, Warrison  Control Clinton  No. 212—40—4918   18 / 19 / 20 / 19 / 20 / 19 / 19 / 19 / 19 / 19 / 19 / 19 / 1	/Medi	cal	Alburn	Swafford		· · · · - · · · · · · · · · · · · · · ·	4b City 3	Town or	Location of Dea	Jan.	24	, 2004	18:39 <sup>M</sup>
Social Social Social Principles   2.5 Social Social Principles   1.5 Social Principles   1.5 Social Social Principles   1.5 Social Prin	Exami	ner					101						••
232-40-4918	Funeral						If Under	1 Year	If Under 24 Hr	s. 8. Date of B	irth		hplace (State or Foreign
17   Father's Name (First, Microlin, Last)   18   Mother's Name (First, Microlin, Majore, Sumano)   18   Mother's Name	Director			1 <del>Q</del> M 2□ F	76	S Yrs.	Months	Days	Hours Min				
17   Father's Name (First, Microlin, Last)   18   Mother's Name (First, Microlin, Majore, Sumano)   18   Mother's Name	yland		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
17   Father's Name (First, Microlin, Last)   18   Mother's Name (First, Microlin, Majore, Sumano)   18   Mother's Name	Mar B-f-s	to	Md. P.G		Uppe	er Ma	ar1bo	oro					1 ☑ Yes 2 ☐ No
T. Father's Name (Frist, Middle, Last)	th the	lre	10e. Street and Number				10f. Zip	Code			10g. C	itizen of What Co	untry?
The part of Name (First, Microtic, Last)   The part of Name (First, Microtic, Majore Summer)	ifh wi	al	5605 S. Marwo	od Blvd.	#133			207	72		Un	ited S	tates
T. Father's Name (Frist, Middle, Last)	r dea	ne	11. Marital Status	Armed Forces?		13.	Was Decede	ent of His	spanic Origin? (	Specify Yes or N	0-	14. Race - Ame	rican Indian,
T. Father's Name (Frist, Middle, Last)	or it	Y		If Yes, Give	No	4						Specify:	
T. Father's Name (Frist, Middle, Last)	ural',	QP										B1	
T. Father's Name (Frist, Middle, Last)	nat occ	lete	15. Decedent's I (Specify only highest g	ducation rade completed)	1	6a. Deced (Give	dent's Usua kind of won	l Occupa k done d	ition <i>juring</i> most of wa	orking	16b. l	Kind of Business/	Industry
The part of Name (First, Microtic, Last)   The part of Name (First, Microtic, Majore Summer)	withir ane.	E D		College (1-4or :	5+)							Drivo	h 0
22. Signified of Funcils Similar Electrons 23. Signified of Funcils Similar Electrons 24. Signified of Funcils Similar Electrons 25. Signified of Funcils Similar Electrons 26. Signified of Funcils Similar Electrons 26. Signified of Funcils Similar Electrons 27. Signified of Funcils Similar Electrons 28. Signified of Funcils Similar Electrons 29. Signified of Funcils Similar Electrons 29. Signified of Funcils Similar Electrons 29. Signified of Funcils Similar Electrons 29. Signified of Funcils Similar Electrons 29. Signified of Funcils Similar Electrons 29. Signified Signified Of Funcils Similar Electrons 29. Signified Signified Of Funcils Similar Electrons 29. Signified Signifi	Hygie ther nt, II			t)			al M			me (First Middl	e Maide		te
22. Significon of Directal Service Licenses 22. Significon of Funeral Service Licenses 23. Significon of Funeral Service Licenses 24. Significon of Funeral Service Licenses 25. Significon of Funeral Service Licenses 26. Service Hill Rd., Suitland, Md. 207 26. Reful: Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Believe and Date of March 1 and Licenses (New York of Date of March 1 and Licenses) 26. Sequentially list conditions. 27. Sequentially list conditions. 28. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Due to (or as a consequence of): 29. Use to (or as a consequence o	od be							-			D, 191010101	n Sumame)	
22. Significon of Directal Service Licenses 22. Significon of Funeral Service Licenses 23. Significon of Funeral Service Licenses 24. Significon of Funeral Service Licenses 25. Significon of Funeral Service Licenses 26. Service Hill Rd., Suitland, Md. 207 26. Reful: Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Believe and Date of March 1 and Licenses (New York of Date of March 1 and Licenses) 26. Sequentially list conditions. 27. Sequentially list conditions. 28. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Due to (or as a consequence of): 29. Use to (or as a consequence o	d Me mark mark	۲				10h Mailie	a Address	(Street a			har City	or Your State 3	Tin Codo)
22. Significon of Directal Service Licenses 22. Significon of Funeral Service Licenses 23. Significon of Funeral Service Licenses 24. Significon of Funeral Service Licenses 25. Significon of Funeral Service Licenses 26. Service Hill Rd., Suitland, Md. 207 26. Reful: Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Believe and Date of March 1 and Licenses (New York of Date of March 1 and Licenses) 26. Sequentially list conditions. 27. Sequentially list conditions. 28. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Due to (or as a consequence of): 29. Use to (or as a consequence o	d 2 s th an th an trau					5605	S .	Mar	wood B	1vd.#	133	or rown, state, 2	.p C009)
22. Significon of Directal Service Licenses 22. Significon of Funeral Service Licenses 23. Significon of Funeral Service Licenses 24. Significon of Funeral Service Licenses 25. Significon of Funeral Service Licenses 26. Service Hill Rd., Suitland, Md. 207 26. Reful: Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Believe and Date of March 1 and Licenses (New York of Date of March 1 and Licenses) 26. Sequentially list conditions. 27. Sequentially list conditions. 28. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Sequentially list conditions. 29. Due to (or as a consequence of): 29. Use to (or as a consequence o	1 an Heel m 2			rd/Wire	20b. Plac	e of Dispo	sition (Nam	e of		d. 207	7.2 20c. I	ocation - City or	Town State
Physician   Middical Examiner	ages nt of r. if it		1 XBunal 2 ☐ Cremation 3		cem	etery, crer	natory or other	her place		00/04			
Physician   Middical Examiner	rtan rtan njury				кеѕс								
Physician   Middical Examiner   Approximate   Approximat	Depa mpo my i		a MICO	L ANDOLL	1					_			
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (or as	a consequen	ce of):	TUM	OR					un Un ows
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9801 Cefansia Ave 3-41 Silvenspring him 20902  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	the death certificate by the death certificate by the attending physic ached for use as the b		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3							
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9861 Cefans in Art 3-41 3. I venspring has 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	signed to	d by P					nderlying ca	use give	n in Part I.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  9801 Cefansia Ave 3-41 Silvenspring him 20902  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	pean peen	ete								24 . 146		1	
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9861 Cefans in Art 3-41 3. I venspring has 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	has has	ш								auto	DSV	prior to c	ompletion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  9801 Cefansia Ave 3-41 Silvenspring him 20902  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	r. Th									1 Yes	2 <b>/</b> 2 No		2 🔯 No
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9861 Cefans in Art 3-41 3. I venspring has 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	iciar certif recto	Be	examiner?	Hospital:				Othe					
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9801 Cefansia Ave 3-41 Silvenspring him 20902  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	Phys this ald			1 Lampatie				-		T			ity)
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9801 Cefansia Ave 3-41 Silvenspring him 20902  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	anding lath.	atlon	1 Natural 5 Pending 2 Accident investigation	on	y Year)					28d. Describe	pow iuin	iry occurred	
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9861 Cefohs in Are 3-41 Silvers print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	tel or Att is after de el Direct ed in by t	Certifle	4-1	289. Place of inj	ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory,	office					ral Route Number,
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9861 Cefans in Art 3-41 3. I venspring has 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	he Hospi n 24 hou he Funer bletely fill	edical	(Check only Z Medical Ext	miner: On the basis of	t examination	dge, death and/or inv	occurred a restigation,	t the time in my opi	e, date and place inion, death occ	e, and due to the urred at the time	cause(s , date an	and manner as d place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  9801 Cefansia Aw 3-41 Silversprains his 20902  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	To the To the Comp	Σ	29b. Signature and title of certifier	/			29c.	License	number		29d. Da	ite signed (Month	. Day, Year)
30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  9861 Crejons in Aw 3-41 3, Ivens PRing him 2092  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			1 Ky Durla	llm			5	04	5-4		Ja.	vuran	24,04
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(5)		30. Name and address of person who	completed cause of d	leath (Item 23	a) (Type,			,				.,,,,,
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			9801 Cephsia	pu 3-41	3,1	vens	PRI'~	9 1	-0 209	02			
Registrar JAN 3 0 2004			31. Date filed (Month, Day, Year)  JAN 3 0 2004	32. Registra				3					

			1 - For Stata Registrar	State of Maryla			Health and	Mental Hyg	iene ag. No. 2004	0449
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day Yeer	3. Time of Death
>	/Medic	cal	Blanche E.	Snyder		41. 03. T		<del></del>	20, 2004	11:07A <sup>M</sup>
	Examin	ier	4a. Facility Name (If not institution, give Millennium Hea			1.1	or Location of De		4c. County of Death	
F	uneral		5. Social Security Number 6. Se		rs. last birthday)	Fotrt If Under 1 Year		rs. 8 Date of Birth	P.G.	place (State or Foreign
	Director		164-38-2334	]M 2[ <b>]</b> √F	91 Yrs.	Months Days	Hours M	in. (Month, Day, Sept. 2	Year) Cou	place (State or Foreigi ntry) VA_
pu	<b>2</b> 134		Usuel Residence of Decedent  10a. State 10b. County	100	City. Town or Lo					
lanyla	shoy a part	7		100.						10d. Inside City Limits 1 Great 2 ☐ No
the M	28a-f	ect	Md. P.G.		Fort	Washin	gton		200	
with	la or	ä	12021 Livingsto	an Dand				'	Og. Citizen of What Cou	
death	ai', or items 23a or 28a-f show Examiner must be notified at	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	2074 Was Decedent of R		(Specify Yes or No-	United St	cates
after	or Items	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ∑No				(Specify Yes or No- erto Rican, etc.)	Black, White,	
72 hours after death with the Maryland	E A	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2및 No	Specify:		Specify: B1	ack
72 h	natural',	Completed	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occup kind of work done	during most of w	rorking	16b. Kind of Business/In	
within	or than	μ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retire	,	_		
Mail y ailly 6 16 15 50000	d other		17. Father's Name (First, Middle, Last)			Housew		ame (First, Middle, M	Privat	e
ould be	E 2 0	To Be	George F. Trac	'V					naidon dannamo,	
should	in and M 7 Is marl traumati	1	19a. Informant's Name/Relationship (Ty	4	19b. Mailin	g Address (Street	and Number or	e Goode	City or Town, State, Zip	Code)
	27 is		Clarke Snyder/s	on	2114	Alice	Ave. ±	£101		
yes 1 a	item 2		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of	rel	nd 2074	20c. Location - City or To	own, State
Pages Part of	int: If		1X Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)			ill Cer		28/04	Suitla	nd Ma
permit. Pages 1 a	Department Important: any injury o		21. Signature of Funeral Service Licens						k Edwards	F.H.
8.2	a di di		Januce E	dwara	1 39	10 Silv	ver Hil	1 Rd., S	Suitland,	Md.20746
/M Exa	ysician fedical aminer	iner	23a. Párty. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a conso	t Cery	ney Si	robine Upt			Approximate Interval Between Onset and Death
death certificate be executed	attending physician and for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a conside.  3c. If yes, outcome of pregalulus pregnant at time of	inancy	Ectopic pregnancy Other (specify)	<b>y</b>		23d. Date of delive	ery Day Year
the d	by the stached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		Other (speed)				
law requires that the	been signed t should be det	by	Part II. Other significant conditions con	ntributing to death but not re	esulting in the un	derlying cause giv	ren in Part I.		acco use contribute to ths s 2 □ No 3 □ Prob	ne cause of death?
The	ate has page 2	Completed						24a. Was an autopsy perform 1  Yes 2	prior to conded? death?	psy findings available npletion of cause of 2 XNo
Physician:		) Be	25. Was case referred to medical examiner?	lospital:	7500	3 DOA Oth		eath (Check only one		
Attending Phy.	After th uneral	ation: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 2 ( 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	+ QQ I val sing	Home 5 ☐ Resider 28d. Describe how	nce 6 □Other ( <i>Specif</i> ) w injury occurred	/)
ital or Atte	To the Funeral Director: Completely filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura State)	I Route Number,
Hospital 4 hours	Funeral i	edical	Check only 2 Medical Examin	sicien: To the best of my kiner: On the basis of examin	nowledge, death nation and/or inv	occurred at the tin	ne, date and place pinion, death occ	ce, and due to the car	use(s) and manner as st	ated. the cause(s)
9 0	the I	Med	one) 29b. Signature and title of gertifier	and manner stated.		29c. Licens				
To	Comp		250. Signature and title of detiller	Minn				29	d. Date signed (Month, I	∪ay, rear)
1	(1)		1/v of	N I''			0210	3	1/22/04	
. {	(4)		30. Name and address of person who co				70 0 -	T		
	Sta	to	Dr. Michael A. 31. Date filed (Month, Day, Year)	☐ 32. Registrar's Sign	nature /	D., 120	7/U 01d	Line Ce	enter, Wal	dorf,Md.
	Registra		JAN 3 0 2004	32. Registrar's Sign	Sports					

			1 - For State Registrar	State of M	laryland /	Depa <i>Cei</i>	artment of H rtificate of L	ealth a D <i>eath</i>	nd Ment	tal Hygie	ne 2 (	104	0 4	98
	Physici		Decedent's Name (First, Middle, La     LUCY ELIZABETH S						N	ate of Death fonth NUARY	Day 26, 20	Yeer 004	3. Time of Dea 2:30P	ath M
	/Medio Examir		4a. Facility Name (If not institution, given PRINCE GEORGES I	e street and number			4b. City, Town, or CHEVE		f Death		4c. County	of Death	EORGES	
	Funeral Director		5. Social Security Number 6. 5 578 66 2498		ge (in yrs. last b	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (A	ate of Birth Month, Day, Yo PR 30,		Cour	place (Stete or Fo htry) INIA	oreign
	e Maryland 3a-f ehow	ctor	Usual Residence of Decedent  10a. State  10b. County  MARYLAND  PRINCE (	GEORGES	10c. City, Tov								0d. Inside City L	
036	d within 72 hours after deeth with the Maryland jene. r than "natural", or items 23s or 28s-1 ehow the Macinal Examinut rust be notified at	by Funeral Directo	10e. Street and Number  8413 HAMT.IN STREE  11. Marrital Status  1 Never Married XX Married  3 Widowed 4 Divorced	ET  12. Was Deceden Armed Forces 1 □ Yes XX If Yes, Give Year or Dates	? ]No	'	10f. Zip Code  20706  Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes ※※ No	spanic Orig n, Mexican, Specify:	in? (Specify ) Puerto Rican	UN Yes or No-		STATE e - Americ k, White,	an Indian, etc.	,
21215-0036	d within giene. r then	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12TH	ducation ade <i>completed)</i> College (1-4or	5+)	(Give life. l	tent's Usual Occupa kind of work done of DO NOT use retired	furing most CANT		Р	b. Kind of Bu	<u> </u>	dustry	
Maryland	should be fited and Mental Hygie marked other umatic event, if	To Be (	17. Father's Name (First, Middle, Last HENRY LEWIS 19a. Informant's Name/Relationship		19	b. Mailir	ng Address (Street a	ETHEL	LEE O	St, Middle, Mai VERHAL ite Number, C	L		Code)	
Baltimore, Ma	permit, Pages 1 and 2 should Department of Health and Men Important: If item 27 le marke any injury or other traumatic QDCB.		MELINDA BUTLER /  20a. Method of Disposition  1X Surial 2 Cremation 3 [ 4 Donation 5 Dither (Speci	DAUGHTER  Removal from State  fy)	20b. Place comete	of Dispo ery, crem NY M 22 MA	GATEWAY F stion (Name of natory or other place IEMORIAL F Name and Addres RSHALL'S	BLVD. PARK 3 s of Facility FUNER	DISTR Date 31 JAN RAL HOM	2004	IGHTS, c. Location - LANDOV	MD City or To VER,	20747 own, State MD	
8760,	ate be executed  hysician and hysician and the burial-transit  the	Ical Examiner	23a. Part1. Enter the disease, or conshock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. FATAL C Due to (or a b. HYPERTE Due to (or a c. CHRONIC	line.  ARDIAC A s a consequence	ARRH of): ARDI	YTHMIA OMYOPATHY		cardiac or resp	piratory arrest			Approximate Interval Betwee Onset and Deat 1 YEAR 1 YEAR 10 YEAR	th
.O. Box 6	death certific ie attending p ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ※□ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pregnancy Other (specify)				23d. Date Mor	e of delive	ery Day Year	r
<u>α</u>	sign d be	þ	Part II. Dther significant conditions	contributing to death	but not resulting	in the ur	nderlying cause give	on in Part I.		23e. Did tobac		ibute to th	ne cause of death	
al Records,	The law ate has b page 2 s	Completed								24a. Was an autopsy performed Yes	d? d	rior to co	psy findings avai mpletion of cause 2 No	lable e of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	- 4797-p.o		Othe		of Death (Che					
o	Jing After fune	ation; To	1 ☐ Yes XX No  27. Manner of Death XX Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpal 28a. Date of In (Month, D		Time of Injury	28c. Injury Work	4 🗀 Nut	28d. [	5 Residenc Describe how			v)	
Division	2 4 4 5	Certification:	3 Suicide 6 Could not to determined	286. Place of II	njury - At home, f alc. <i>(Specify)</i>	arm, str	eet, factory, office			ocation (Stree city or Town, S		er or Rura	l Route Number,	
	the Hospital in 24 hours a the Funeral t pletely filled	ledical	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	of examination a		restigation, in my op	inion, death		the time, date	and place, a	ind due to	the cause(s)	
•	To the within To the comple	M	29b. Signature and title of certifier	63	gu.	4			60	1	Date signed	(Month,	uay, reari	
_	(J)		30. Name and address of person who OLG SHPAK	121 C	)MGRESSI		L LANE #3	12 I	ROCKVII	LLE, MD	20852	2		
	Sta Registi		31. Date filed (Month, Day, Yeer)  JAN 3 0 2004	32. Regis	trar's Signature	wh	,							

04 dá	1-00962 ap		Please Type or Prii For Amended Item#1,4aState of Massate Properties Unpended Item#23a,27,28a	aryland / Depa	artment of Health	and Mental Hy	giene 2001	04490
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last)  Paul Charles Sukalo,		<b>зухуявя ине</b> досан	2. Date of De	Reg. No. ath RY 3,2004	3. Time of Death 11:40 a M
A. C.	Examin		4a. Facility Name (If not institution, give street and number) 3906 CALAWASSA EVAD 3906 C	alawasse Road	4b. City, Town, or Location EDGEWATER	n of Death	4c. County of Death ANNE ARUNE	יבור
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 216–19–8698 2.	e (In yrs. last birthday) Yrs.		8. Date of Bir (Month, Da Mar. 1	th 9. Birth	place (State or Foreign intry) Land
	ahow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	e Mar	ctor	Maryland Anne Arundel	Lo	thian			1 ☐ Yes 2 X No
	with th	Funeral Director	10e. Street and Number		10f. Zip Code 20711		10g. Citizen of What Cou	ntry?
	Jeath Tag 23	erai	5809 Sonny Drive  11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Of Yes, specify Cuban, Mexica	origin? (Specify Yes or No	USA - 14. Race - Ameri	
920	ours after o rai', or iter Examiner	þ	Armed Forces?  1 XNever Married 2 Married 1	No	f Yes, specify Cuban, Mexica 1 ☐ Yes 2🌠 No <i>Specif</i> y		Black, White,	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Itema 23a or 28a-f ahow other tran "hatural", or Itema 23a or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or:	life.	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Business/Ir	
	Hygie other	Be Co	17. Father's Name (First, Middle, Last)	Euri		her's Name (First, Middle		,,,,
Maryland	Mental Mental arked	To B	Paul Charles Sukalo	. Sr	Id	da M. DeCesa	ris	
Man	12 sho		19a. Informant's Name/Relationship (Type, Print)		Gonner Decises			
Baltimore, I	Pages 1 and nent of Health ant: If item 27 ury or othar 1		Paul C. Sukalo, Sr./ Fathe:  20a. Method of Disposition  15 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, crer	Sonny Drive, sition (Name of natory or other place)	Date	20c. Location - City or To	own, State
Baltir	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Licensee	22	of Sorrows Name and Address of Faci Name The Company of The Company of Faci Name The Company of The C			al Home
M	Physician /Medical Examiner	j.	resulting in death)  Due to (or as	ne.	Phencyclidine(PC			Intérval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	a consequence of):				
O. Box	ath certif ttending or use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying cause given in Part		obacco use contribute to t Yes 2 No 3 Prol	he cause of death?
al Records,	icien: The law requicertificate has been ector, page 2 should	Completed				24a. Was auto perfo 1 Yes	osy prior to co ormed? death?	ppsy findings available impletion of cause of
Vital		o Be	25. Was case referred to medical examiner?  1 ★ Yes 2 ☐ No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatier	Othor	ce of Death (Check only o	one) dence ∯∭(Other (Speci	AT SCENE
on of	ding After fune		27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju	vrv 28b. Time or		28d. Describe	how injury occurred	MI SCHVII
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	Carlet not be	jury - At home, farm, str tc. (Specify)		28f. Location (. City or To	Street and Number or Run wn, State) awasse Rd.,Edge	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medicel Exeminer: On the basis of and manner state.	of examination and/or in	n occurred at the time, date a vestigation, in my opinion, de	and place, and due to the	cause(s) and manner as s	tated -
	To th withir To th comp	Me	29b. Signature and title of certifier  Rahimah Afri		29c. License number OCME		29d. Date signed (Month, FEBRUARY 4, 2	
			30. Name and address of person who completed cause of a ZABINCLAH ALL		Penn Street,	Baltimore,	Maryland 212	201

State Registrar 31. Date filed (Month, Day, Year) FEB 1 2 2004

32. Segistrar's Signature

			1 - For State Registrar	State of Maryland			lealth a	and M	lental Hygi	ene g. No. 200	4 04500
	Dhusis		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day Va	3. Time of Death
*	Physici /Medi		Earl Er	nest Sizemore					February	Day Yea 7 3 200	
	Examir		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, or	Location o	of Death		4c. County of De	eath
			981 Blue Ball Roa			Elkton				Cecil	
	Funeral		5. Social Security Number 6. Sex	M SETE	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	9. E	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	91	115.				NOV 22,	1912 We	st Virginia
	Man and		10a. State 10b. County	10c. City, T	own or Lo	ecation					10d. Inside City Limits
	Many f sh	Ö	Maryland Cecil	FIL	ton						1 ☐ Yes 2X No
	286 100	Director	10e. Street and Number	יידע	LOII	10f. Zip Code			100	g. Citizen of What	Country?
	3a o		981 Blue Ball Road	٦		21921				United S	•
	death	Funeral		12. Was Decedent Ever in U.S.	13.	Was Decedent of Hi Yes, specify Cuba	ispanic Orig	gin? (Spe	cify Yes or No-	14. Race - Ar	nerican fndian,
ဖွ	after or ite	Ī	1 ☐ Never Married 2 ☑ Married	Armed Forces? World  1 Myes 2 No War I	т	1 Tes, specny Cuba 1□ Yes 2⊠ No	n, mexican Specify:	, Puerto	Hican, etc.)	Black, Wi	hite, etc.
21215-0036	be filed within 72 hours after death with the Marylend tial Hygiene. Independent metural, or items 23a or 28e-f show event, the Medical Examination by crotilise at	d by	3 Widowed 4 Divorced	Year or Dates:		163 223110	зреспу.			Specify:	White
7	"netu	Completed	15. Decedent's Edu (Specify only highest grade		6a. Deced (Give	dent's Usuaf Occupa kind of work done of DO NOT use retired	ation Juring most	of worki	ng 16	6b. Kind of Busines	ss/Industry
2	within ene. then *	E G	Elementary/Secondary (0-12)	College (1-4or 5+)							
	filed Hygie ther ther and, it	ပ္ပ	17. Father's Name (First, Middle, Last)		EL	ectrician		r's Nama	(First, Middle, Ma	Industr	ial
an	Aental rked o tic eve	Be		Ciromoro						uden Sumame)	
2	should nd Men marke umatic	ို	George Washington 19a. Informant's Name/Relationship (Ty)		Oh Maifie	ig Address (Street a			inehart	Site on Town Canto	7:- 0-4-1
Maryland	d 2 s ith ar 27 is 1 treu		Frances I. Sizemon			lue Ball					
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of				oc. Location - City of	
Baltimore,	e ° = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☒ Other (Specify)]	emoval from State Harf	ord l	matory or other place Memorial	1 -	'ebru	ary		
₫	permit. Page Department o mportent: If any injury or ance.		21. Signature of Funeral Service License		22	Name and Address	s of Facility	J		el Air, I	Maryland
B	permit. Departn importe any inju		1	Hickory	Hi	.cks Home	for I	Funei	cals, P.A	Α.	
			23a. Part1. Enter the disease, or compli	cations that caused the death.	o not ent	3 W. Stoo	such as o	SET 6	r respiratory arres	on, Mary	Approximate
	Pnysician		snock, or near tailure. List only on immediate Cause (Final	e cause on each line.	- 1	7.	10	(	1		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	to (or as a consequence	ce of):	Len	17	en	me		2 wics
	Examiner		and the second second	Donal	6	110	12	2-52-	maa		1 months
		Je l	Sequentially fist conditions, if any, leading to immediate	Due to (or as a consequence	ce of):				/		1
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	Conpos	371	e He	سرات	1-	Felu	ر ب	2 WRS -
Ö,	e exe ian aı urial-t		resulting in death) Last	Due to (or as a consequence	e of):	ſ		,/	. 0 0		
8760,	ate be executed obysician and the burial-transit	Ilcal		1xyer	had	DanCl	m C	7551	- Vilm	nay	2000
9	e as t	Physician/Med	IF FEMALE:	A se sa se se se se se se se					E	775ene	
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea		Ectopic pregnancy				23d. Date of d	elivery Day Year
<u>.</u>	he de the a hed f	/sic	1 ☐ Yes 2 ☐ №6 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5	Other (specify)				IVIOTILIT	Day Teat
P.O.	that the death certific ed by the attending p detached for use as		Part II. Other significant conditions con	tributing to death but not resulting	n in the ur	iderlying cause give	o in Part I		23a Did tobar	no uso contributo	to the cause of death?
ds,	signed d	d b	•		9 41 (110 11	loonying oddso give	ii ai i Qaici.				Probably 4 Dunknown
ŏ	w requir been si should I	ete				·		_	-		
Records,	has l	Completed							24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
<u></u>	Attending Physicien: The law requires that the death certificate be executed redeath.  - death.  - death.  - etoric articlete has been signed by the attending physician and yother funeral director, page 2 should be detached for use as the burial-transit.	ပိ	Of West and the section						1 ☐ Yes 2 Ē	24√6 1 □ Ye	s 2 No
Division of Vital	sicie r certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2	Othe	-		(Check only one)		
o	y Phys ar this aral dii	-	27. Manner of Death	28a. Date of Injury 28b	. Time of	28c. Injury Work	4   Nui:	-	8d. Describe how	e 6 Other (Spiniury occurred	ecify)
<u></u>	th. :: Afte	ᅙ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2.∐N			,.,	
N N	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	farm, stre	et, factory, office		2	8f. Location (Stree	at and Number or F	Rural Route Number,
	ei or s afte ii Dir	Certification:	4 Homicide	building, etc. (Specify)					City or Town, S	State)	
	ospit houn unere ly fille		29a. Certifier 1 Certifying Phys	cian: To the best of my knowled	lge, death	occurred at the time	e, date and	place, a	nd due to the caus	e(s) and manner a	as stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	51107	er: On the basis of examination and manner stated.	and/or inv	estigation, in my opi	inion, death	1 occurre	d at the time, date	and place, and du	e to the cause(s)
,	To with	2	29b. Signature and title of certifier	P.W. Vet		29c. License	number	_	29d.	Date signed (Mon	th, Day, Year)
			1/24-11/2		1711	W	3	_/	t	eb4,	2004
			30. Name and address of person who con	npleted cause of death (Item 23a	(Type, f	Print)	1 A	10	EINT	014, m	7
	Sta	10	31. Date filed (Month, Day, Year)	M32. Registrar's Signature	1230	singen	7111	1	- LKI	OIT IT	
	Registr		FEB 1 2 2004	14 TELMI) 32. Registrar's Signature	See A						